

**Do Clinical Psychologists Have a Role in Clients' Use of Psychotropic
Medication? A Mixed Methods Investigation Exploring Current Forms
of Involvement**

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Portfolio Abstract

Background: Involvement with psychotropic medication is not traditionally viewed as an aspect of the clinical psychologist's job, and there are currently no professional guidelines advising on a role. International research suggests that psychologists are likely to encounter a variety of opportunities to become involved, and are frequently (indirectly) involved in the process of prescribing and managing of clients' psychotropic medications. There is a lack of research into psychologists' involvement with psychotropic medication in the United Kingdom (UK), but given the widespread use of psychotropic medication similar opportunities and practice may occur. The collective clinical psychology profession is also taking an increased stance against biological approaches towards mental health, such as issuing guidance on use of diagnosis and promoting movement away from its use. The question remains as to whether the professional movement with diagnosis extends into any role with psychotropic medication, be this a critical stance or any other.

Aims: This study aimed to explore whether clinical psychologists in the UK have a role with their client's psychotropic medication by exploring forms of involvement undertaken, and decision-making behind involvement.

Method: A mixed method design was employed; 147 clinical psychologists took part in an online survey, and 11 respondents were interviewed. Descriptive statistics, logistic regression, and thematic analysis were used to analyse the quantitative and qualitative data respectively.

Results: Results suggest that clinical psychologists are engaging in various forms of involvement with medication on a regular basis, often with intent to influence prescribing based on their agendas. A thematic map was created identifying a process by which clinical psychologists weigh up factors prior to deciding to have involvement in order to establish their rationale, and then flexibly navigate their approach and actions. This all occurs within the context of professional uncertainty and conflict, under dominant societal narratives around epidemiology of mental health difficulties and the effectiveness of medication.

Following involvement, participants reflected on their strategy which led them to consider future approaches.

Conclusions and Recommendations: Findings echo previous international research; clinical psychologists recruited in the study are regularly engaging in roles with their client's psychotropic medication. This is despite lack of guidance from professional bodies, no professional position statement, and minimal (or no) teaching during training. To the author's knowledge this is the first study to explore the topic area within the UK. Study findings are considered important due to uncovering the extent to which involvement forms part of the role, which was previously unknown. Findings translate into two main clinical implications: 1) supporting the idea of training on psychotropic medication for clinical psychologists, and 2) professional guidance to inform clinical psychologists' practice.

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Statement of Contribution

Thesis Research Project Design

Amy Aston (supervised by Sharron Smith and Danielle De Boos).

Application for University Ethical Approval

Amy Aston (supervised by Sharron Smith and Danielle De Boos).

Literature Review

Amy Aston.

Participant Recruitment

Amy Aston designed the recruitment process and recruited participants for the online survey (supervised by Sharron Smith and Danielle De Boos).

Amy Aston and Sharron Smith both selected participants for interviews using a systematic selection process.

Data Collection

Amy Aston.

Transcription

Helen Smith (transcription services).

Data Analysis

Amy Aston with support from Danielle De Boos and Anna Tickle.

Write-up

Amy Aston (supervised by Sharron Smith and Danielle De Boos with additional supervisory input from Anna Tickle).

Systematic Review

Amy Aston with support from Danielle De Boos. Amendments were made based on feedback given by Roshan das Nair and Thomas Schroeder.

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Systematic Review

Clinician and Service User Perspectives of Shared Decision Making Interventions in Mental Health Services: A Meta-Ethnographic Synthesis

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Abstract

Background. Shared Decision Making (SDM) is an emerging area of research in mental health. The SDM model is defined as a collaborative process between a client and a practitioner whereby both parties bring their own expertise in order to arrive at a healthcare decision.

Aims. The aim of this review was to identify, appraise, and synthesize the current qualitative literature exploring health clinician and service user perspectives of SDM interventions used in mental health settings.

Methods. A comprehensive systematic search of the literature was conducted. Six qualitative and two mixed method studies met the inclusion criteria. An appraisal tool was used to assess their quality, and a meta-ethnographic approach was used to synthesize the data extracted.

Results. Third order themes centred around: barriers to facilitating SDM, the notion of power, and the therapeutic relationship. Particular clinician barriers were identified, alongside a shared difficulty in adjusting the power balance.

Conclusions. SDM interventions may be effectively implemented by supporting clinicians via training and supervision, emphasizing the importance of establishing an initial relationship and 'setting the scene' for SDM, and focusing on dialogue to build the therapeutic relationship.

Declaration of Interest. No conflict of interest reported.

Background

Shared Decision Making

Various models of the clinician-patient relationship have been proposed, each with differing degrees of power located with the patient. The paternalistic model which has traditionally been the dominant model in healthcare (Duncan, Best, & Hagen, 2010) proposes that the power and responsibility lies with the clinician, who will take the lead in healthcare decisions. The informed decision making model contrasts this in that the clinician acts solely as a source of information, and all decision making capacity lies with the patient (Shepherd, Shorthouse, & Gask, 2014). The shared decision making (SDM) model is proposed as a middle ground between the two. It is defined as a collaborative process between a client and a practitioner whereby both parties bring their own expertise in order to exchange information, clarify values, and work together to arrive at a healthcare decision (Charles, Gafni, & Whelan, 1997).

Shared Decision Making within Mental Health

SDM is increasingly advocated as an ideal model of treatment decision making in healthcare (Duncan et al., 2010). To date, SDM has primarily focused on physical health, particularly in primary care settings (Barry & Edgman-Levitan, 2012; Davis et al., 2003). There is a growing awareness however of the need for SDM to extend in to mental healthcare (Stacey et al., 2016). In the United Kingdom, policy framework within mental health has shifted with the aim to reassess the role of the 'patient' within their own care. This follows movements advocating an increase in service user choice such as within consumerism models of healthcare and the mental health service user movement (Department of Health, 2001, 2012). Research also suggests that those who meaningfully participate in treatment planning are more likely to meet their treatment goals and be satisfied with services (Bassman, 1997; Liberman, Hilty, Drake, & Tsang, 2001; Roth & Crane-Ross, 2002). SDM in mental healthcare is therefore an emerging area of research and an idealised treatment approach, as recognised in National Institute of Health and Care Excellence (NICE) guidelines for mental health conditions (termed 'patient-centred care') and as demonstrated by an increase in 'decision aids' within the National Health Service (National Health Service, 2016).

Shared Decision Making Interventions

Research focusing on SDM has highlighted obstacles such as: time constraints, limited service user interest, (Légaré & Witteman, 2013), limited staff agreement and motivation (Légaré, Ratté, Gravel, & Graham, 2008), and presumption of roles (Joseph-Williams, Elwyn, & Edwards, 2014). The focus of much research has been to consider how SDM is experienced within everyday practice (e.g. Eliacin, Salyers, Kukla, & Matthias, 2014; Chong, Aslani, & Chen, 2013). There has been an increase in adopting an active approach to SDM however in the form of specific interventions, with an aim to overcome these barriers. As the concept of SDM as an intervention is in the early stages, there is no current method of best practice and services are therefore approaching this by using experimentation and creativity. Examples include: mobile phone decision aid applications, computer-based programs, and peer-led support centres (Deegan, Rapp, Holter, & Riefer, 2008; Korsbek & Tønder, 2016). Charles et al. (1997) proposed specific criteria in order for information exchange to qualify as SDM, which have been widely acknowledged in SDM research (Duncan et al., 2010). The current review has considered these in terms of inclusion criteria (Appendix A).

A Cochrane review (Duncan et al., 2010) assessed the effects of SDM interventions for people with mental health conditions, but as only two studies were found to meet inclusion criteria it was not possible to draw any firm conclusions on the efficacy of the interventions. There is a growing body of qualitative literature exploring how both clinicians and service users experience these interventions. This is important as qualitative research is acknowledged as vital in evidence based healthcare as it represents consumers experiences and provides a voice outlining preferences and priorities (Evans, 2002).

Aims of the Present Review

To explore the perspectives of individuals who have experienced SDM interventions a review of the existing literature was undertaken using a meta-ethnographic approach. The overall aim of this review was to respond to the question: "What are clinician and service user experiences of engaging with

SDM interventions?”. Qualitative research aims to seek detailed complex interactions and allows the researcher to explore the experiences of meanings in context (Joffe, 2011). Meta-ethnography is an interpretative approach that aims to synthesise findings across qualitative studies to provide a higher level of analysis and new research questions. We anticipated that synthesizing the perspectives of two groups would facilitate comparisons, and lead to a foundation from which to move forward with SDM interventions in mental healthcare.

Methods

The review comprised three stages: a systematic search of the literature, critical appraisal of included studies, and a meta-ethnographic synthesis as described by Noblit and Hare (1988).

Searching

The following electronic social science and medical databases were searched: PsycINFO (1806-present), Medline (1996-present), Cumulative Index of Nursing and Allied Health Literature (CINAHL; 1981-present), SCOPUS (1960-present), EMBASE (1980-present) and Web of Science (1900-present). Supplementary searches were also conducted to increase the comprehensiveness of the search and to minimise the risk of excluding relevant papers including perspectives (Evans, 2002). This included ‘grey literature’ databases (Opengrey and Ethos), British Psychological Society publications, and a free text Google Scholar search. Reference lists of included papers were also hand searched.

Previous reviews on SDM have advocated using a simple search of the phrase “shared decision making” in titles and abstracts (Makoul & Clayman, 2006; Shay & Lafata, 2015). This was felt to contain risks of accidental exclusion, therefore a comprehensive search strategy was created. Terms were derived following scoping searches and consideration of search terms used in similar reviews. The following terms were used both singularly and in combination, and exploded as appropriate to each database: -

Shared decision making, shared decision making model, decision aid*, decision making, decision support technique*, treatment decision making, mental health, mental health service*, mental health condition*, mental health disorder*, mental illness, emotional disorder*, perspective*, perception*, attitude*, opinion*, experience*, view*, belief*, involvement, account*, response*, understanding, qualitative, qualitative research.

Inclusion and Exclusion Criteria

Studies were required to include (1) a shared decision making intervention that was implemented within a mental health service, and (2) the perspectives (e.g. attitudes, views, opinions) of clinicians and/or service users who had been involved in the intervention. The term 'clinician' is inclusive to a variety of professions and perspectives of clinicians were not excluded based on their profession. There were no exclusion criteria based on characteristics of service users, and papers including perspectives of both health clinicians and service users were included. Mixed method studies with a qualitative component were also included.

Studies were included based on the following criteria: -

- 1) Study reported carrying out an intervention specifically aimed towards SDM
- 2) Intervention was conducted in a mental health setting
- 3) Included the first hand perspectives of either a clinician or service user who experienced the intervention
- 4) Use of a qualitative method for data analysis
- 5) Written in the English language

Studies were excluded based on the following: -

- 1) The intervention did not meet the SDM criteria as outlined by Charles et al. (1997)
- 2) The study explored aspects of SDM in treatment as usual
- 3) SDM intervention was for a physical health condition

Selection

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement was used to outline article selection (Moher, Liberati, Tetzlaff, & Altman, 2009) as presented in Figure 1. Following the search process, duplicates were removed and abstracts were screened against the inclusion criteria. The remaining full text articles were then screened against exclusion criteria.

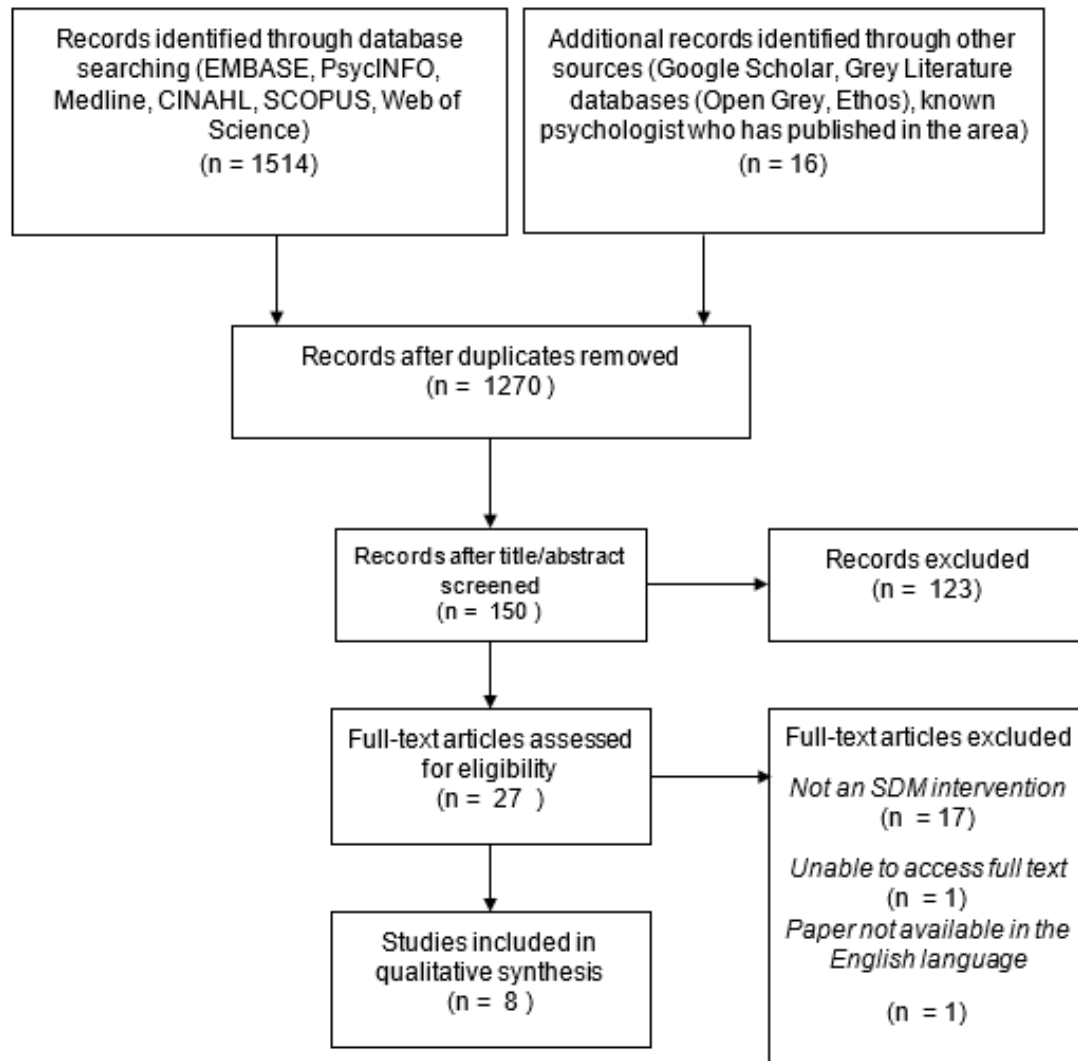


Figure 1. PRISMA diagram

Data Abstraction

The synthesis process was informed by Noblit and Hare's (1988) meta-ethnographic seven-phase approach. This interpretative form of synthesis aims to propose a new level of understanding, as opposed to integrative reviews which provide "a basic comparability between phenomena" (Noblit & Hare, 1988, p.15). The studies were read, re-read, and the relevant data was extracted using a data extraction tool in order to inform the quality appraisal and synthesis process.

Meta-ethnography consists of three synthesis methods: translating themes/concepts from one study to another (reciprocal translations), considering the implied relationship between contradictory findings (refutational analysis), and reflecting on the synthesised information to interpret the findings as a 'whole' (line-of-argument synthesis). The synthesis in the present review did not incorporate refutational translations as despite different outcomes, findings pointed towards mutual conclusions.

Reflexivity

The product of qualitative research is invariably shaped by the researcher and their position on the given subject. During the process of meta-ethnography, the analyst is translating studies into their own world view (Noblit & Hare, 1988) therefore transparency is considered fundamental for good quality qualitative synthesis (Finlay, 2006). The primary author's interest in SDM stems from past work experience whereby service users' opportunity for decision making was not always apparent. This resulted in observed coercion and disempowerment for service users, and translated into a desire to increase service user collaboration and involvement in decision making. To minimise bias placed on clinicians for not allowing SDM to occur (given past experience) attention focused on the interpretation of *why* SDM may have been unsuccessful, rather than fixating on where blame may lie.

Results

From the initial 1,514 records identified, 27 full text articles were reviewed. Nineteen were excluded for not meeting the inclusion criteria. Reasons for this were due to exploring SDM in treatment as usual and not as part of an intervention ($n = 17$), the paper being unavailable in the English language ($n = 1$), and inability to access the full text ($n = 1$). Eight articles were included in the synthesis including a total of 260 participants (126 clinicians, 134 service users). A summary of study characteristics can be found in Table 1. All studies but one (Deegan et al., 2008) were published in the last five years, suggestive of SDM in mental health being an emerging area of research.

Table 1.

Study Characteristics

Study No	Authors, year of publication and country	Participants (N)	Context of recruitment	Data analysis method	Shared decision making intervention	Research aims
1	Abrines-Jaume <i>et al.</i> , 2016, UK	<i>Clinicians</i> N = 23 (psychiatrists, psychologists, nurses, family therapists, social works, play therapists)	4 NHS CAHMS mental health services	Framework analysis	Staff training	What are the barriers to implementing SDM in CAMHS services?
2	Farrelly <i>et al.</i> , 2016, UK	<i>Clinicians</i> N = 45 (29 care coordinators, 16 psychiatrists) <i>Service users</i> N = 51	Within a larger trial conducted in 4 mental health trusts in England	Grounded theory	Joint Crisis Plan (JCP) for psychosis	How do clinicians and service users experience the JCP intervention?
3	Goscha & Rapp 2014, USA	<i>Clinicians</i> N = 9 (3 prescribers, 5 case managers, 1 case management team supervisor) <i>Service users</i> N = 12	Community mental health centre	Grounded theory	CommonGround: computer based tool	How is CommonGround experienced by staff and service users?

Table 1 cont.

Study Characteristics

Study No	Authors, year of publication and country	Participants (N)	Context of recruitment	Data analysis method	Shared decision making intervention	Research aims
4	del Barrio, Cyr, Benist, & Richard 2013, Canada	<i>Service users</i> N = 26	8 Community based mental health organisations	Not reported	Autonomous medication management: a dialogue/peer support approach	How does the intervention influence the ways in which service users relate to their medication?
5	Korsbek & Tønder, 2016, Denmark	<i>Clinicians</i> N = 19 (nurses, occupational therapists, psychologists, social workers, doctors) <i>Service users</i> N = 7	Mental health community centre	Not reported	Momentum: a smartphone application	Does the use of the decision tool affect the experience of participation in treatment consultations?
6	Deegan, Rapp, Holter & Riefer, 2008, USA	<i>Clinicians</i> N = 18 (14 case management staff, 4 medical staff) <i>Service users</i> N = 16	Urban mental health centre	Not reported	Transformation of a typical waiting area into a peer-run decision support centre (DSC)	To describe participants experiences in using the DSC

Table 1 cont.

Study Characteristics

Study No	Authors, year of publication and country	Participants (N)	Context of recruitment	Data analysis method	Shared decision making intervention	Research aims
7	Bonfils <i>et al.</i> , 2016, USA	<i>Clinicians</i> N = 12 (supervisors, peer specialists, registrars, psychiatrists, and upper management)	Two assertive community treatment teams and two outpatient teams	Study is mixed methods: Qualitative method used content analysis	CommonGround: a computer based tool along with a decision support centre	To explore the current CommonGround implementation process and indentify strategies to enhance the programs impact at future sites
8	Moncrieff, Azam, Johnson, Marston, Darton & Wood, 2016, UK	<i>Service users</i> N = 22	Community recovery teams	Thematic analysis	Medication Review Tool: a website to access information and a downloadable tool	Can the medication review tool help patients assess and communicate more effectively about the risks and benefits that taking psychiatric medication involves?

Quality Appraisal

Despite extensive research on the appraisal of qualitative research there remains a lack of consensus on definitive criteria, potentially due to the heterogeneity of methods (Walsh & Downe, 2006). This review utilised the Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2013) as a tool to evaluate the methodological quality of the included studies; a summary of which can be found in Table 2. Papers were rated separately by the two authors; discrepancies were discussed and final scores agreed upon.

Table 2.

CASP Criteria

CASP criteria	1	2	3	4	5	6	7	8
Clear statement of aims?	Y	Y	Y	Y	Y	Y	Y	Y
Qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y
Research design appropriate to aims?	Y	Y	Y	Y	Y	Y	Y	Y
Recruitment strategy appropriate to aims?	Y	Y	Y	Y	Y	Y	U	U
Data collected in a way that addressed the research issue?	Y	Y	Y	Y	U	U	Y	N
Relationship between researcher and participants adequately considered?	N	N	N	N	Y	N	N	N
Ethical issues taken into consideration?	N	Y	N	N	N	N	Y	Y
Data analysis sufficiently rigorous?	Y	Y	Y	U	U	N	Y	U
Clear statement of findings?	Y	Y	Y	Y	Y	U	Y	N

Note: Y = Yes, N = No, U = Unclear

The process of critically appraising qualitative literature lends itself to the philosophical assumption that qualitative research can be flawed, and that inclusion of such studies may result in a flawed meta-synthesis (Walsh & Downe, 2006). Two studies did not meet the majority of the CASP criteria (Deegan et al., 2008; Moncrieff et al., 2016) which may suggest caution in interpreting the study's findings. In consideration to weighting the papers within the synthesis, as the findings in the study by Deegan et al. (2008) weren't particularly controversial, it was deemed appropriate to include them.

Furthermore, research has found that including studies deemed poorer quality is unlikely to distort the synthesis (Campbell et al., 2011). The study by Moncrieff et al. (2016) was excluded however following quality appraisal. Despite reporting that they used thematic analysis, no themes were reported in their results and the quantity of qualitative data reported was extremely minimal. It was therefore considered to add little value to the synthesis.

All studies outlined clear aims for their research, and a qualitative methodology was deemed appropriate for their research questions. Ethical considerations were largely absent, as description of ethical approval was present in just three studies (Bonfils et al., 2016; Farrelly et al., 2016; Moncrieff et al., 2016).

Reflexivity is considered an important aspect of qualitative studies in order to increase credibility and the rigour of the research process (Jootun, McGhee, & Marland, 2009). A researcher's beliefs and values will influence their approach to the methodology and analysis, however none of the studies reported their epistemological perspectives or included any reference to reflexivity. Two studies did address potential bias wherein the researchers helped develop the technology behind the intervention so therefore had competing interests (Korsbek & Tønder, 2016; Deegan et al., 2008). This is reported as a limitation within both papers. One study reported that the research team had a long-standing relationship with the centre in which the research was conducted, but did not state how this may affect the research (Bonfils et al., 2016). Six of the studies used direct quotes as a substantial part of their findings which supports the reader in understanding how conclusions were made. Two studies included brief and infrequent quotations only; the extent to which the findings were substantiated by the raw data is questioned (Deegan et al., 2008; Moncrieff et al., 2016).

The CASP has attracted criticism for not requiring researchers to specify the method of data analysis used within the study (Walsh & Downe, 2006). Three studies do not explicitly state their method of analysis but report that they identified significant patterns or themes (Korsbek & Tønder, 2016), carried out codification based on emerging themes (del Barrio, Cyr, Benisty, & Richard, 2013) or in one case appear to have used content analysis by summarising

findings into headings (Deegan et al., 2008). The process by which findings were derived is therefore unclear, limiting the quality of papers. However due to an inability to access raw data, findings were taken at face value for the purpose of synthesis, with this acknowledged as a limitation.

Studies were not awarded a score based on quality appraisal as this assumes that each category holds the same weight. Overall, six studies were deemed to be of reasonable quality, and two of lower quality (Deegan et al., 2008; Moncrieff et al., 2016). Two of the papers were mixed methods (Bonfils et al., 2016; Moncrieff et al., 2016); only the qualitative aspects were subject to quality appraisal. The quantity of qualitative data within the mixed methods papers was substantially less than the purely qualitative papers; particularly in the study by Moncrieff et al. (2016).

Summary of Findings

The nature of the intervention varied across all six studies, some aimed to improve SDM specifically in regards to medication whereas some aimed for more collaboration in overall mental health treatment. The variance in intervention and context is considered during the synthesis. A summary of the interventions can be found in Table 3. The majority of studies report positive outcomes as a result of the SDM interventions, however one predominantly reports on the barriers to SDM which appears a result of unfavourable outcomes of the intervention (Farrelly et al., 2016).

Interpretation of Findings

The meta-ethnography identified third order constructs that can be categorised by three key themes: (1) Barriers to shared decision making [subthemes: changing roles, clinician exposure]; (2) Power [subthemes: transferring of power, achievability of true shared decision making, protective withholding, mistrusting withholding]; (3) Therapeutic relationship [subthemes: prerequisite or goal?, authenticity of the relationship]. The presence of themes within studies is outlined in Table 4.

Table 3.

Summary of SDM interventions

Shared Decision Making (SDM) Intervention	
Abrines-Jaume <i>et al.</i> , (2016)	<p>Across two years staff received regular training events (one every three months) which included provision of information and materials, group discussions, and action learning sets. Clinicians were also supported in implementation of approach and use of the tools via regular site meetings, and phone and email guidance. Details of these tools are not provided in the study.</p> <p><i>SDM aims:</i> Overall treatment in therapy</p>
Farrelly <i>et al.</i> , (2016)	<p>Clinicians engaged with service users to develop a Joint Crisis Plan (JCP) as part of a larger randomized control trial. The JCP contains the service users preferences for treatment in the event of a future relapse of their mental health condition. The plan is jointly made with the service user's psychiatric team. There are two meetings during this process; the first is attended by the care coordinator, the service user, and a JCP facilitator. The service user is given a list of options they would like to consider using in their JCP, and they are then given time to consider this and prepare for the second meeting. The second meeting entails the creation of the JCP with the service user, their clinical team (care coordinator and psychiatrist), the JCP facilitator, and the service user's family members.</p> <p><i>SDM aims:</i> Specific to a care plan in event of relapse</p>
Goscha & Rapp (2014)	<p>CommonGround, a web-based SDM application was introduced. It comprises six components: (1) Prior to the medication consultation service users work with a case manager to develop a Power Statement – a self-advocacy statement setting the tone for exploring considerations regarding the use of medication. Service users also identify Personal Medicine which are self-initiated, non pharmaceutical, self-care activities that the service user values and deems helpful to their mental health. (2) Prior to meeting with the prescriber, service users answer questions on a touchpad screen located at a kiosk in the waiting room. (3) The information is collated into a report, and support is provided to help the service user understand the report and form any questions they have prior to the consultation. (4) The CommonGround report is taken into the medication consultation and reviewed together. (5) A SDM format is used by the prescriber in terms of them reviewing each aspect of the report and exploring the service user's subjective experience of their situation, and any uncertainty regarding use of medication. (6) The CommonGround report is updated to reflect the shared decision and shared with the rest of the service user's treatment team.</p> <p><i>SDM aims:</i> Decisions about the use of psychiatric medication</p>

Table 3 cont.

Summary of SDM interventions

Shared Decision Making (SDM) Intervention	
del Barrio, Cyr, Benist, & Richard (2013)	<p>The Autonomous Medication Management approach aims to support practices so that service users can identify changes they wish to make and utilise the available resources to ensure that medication is contributing to their wellness. The focus is on making room for dialogue between the service user, their loved ones, peers, and the professionals they encounter. Service users have accessibility to information regarding medication, individual support to prepare for meeting prescribing physicians, and opportunities for expression and discussion with peers to consider experiences with medication. A guide is also provided to support the service user throughout the process and provide information.</p> <p><i>SDM aims:</i> Decisions about the use of psychiatric medication</p>
Korsbek & Tønder (2016)	<p>Momentum is a smartphone application (app) consisting of a treatment site where clinicians can see the preparations that service users choose to share. The app has an interactive element which allows service users to prepare for treatment consultations through a series of guided questions before deciding which topics they consider central for the meeting. Following the consultation the user can evaluate the meeting and how useful they felt the app was in terms of preparation. There is also an element to the app that includes a tool to develop coping strategies.</p> <p><i>SDM aims:</i> Overall treatment in therapy</p>
Deegan, Rapp, Holter & Riefer, (2008)	<p>A psychiatric medication clinic was transformed into a peer-run Decision Support Centre (DSC). Services included: offering a snack and beverage, assisting service users in creating a report for use in the medication consultation, giving service users access to health-related information via the internet, providing informal peer support, and providing support with completing decision aids used for addressing areas of conflict in regards to medication. The computer program consists of an introductory to recovery as written from a peer perspective, vignettes of others talking about their recovery, and information of Personal Medicines; enjoyable activities that can contribute to wellness. A survey is also completed concerning perceived symptoms and psychosocial functioning which can be customised.</p> <p><i>SDM aims:</i> Decisions about the use of psychiatric medication</p>

Table 3 cont.

Summary of SDM interventions

Shared Decision Making (SDM) Intervention	
Bonfils <i>et al.</i> , (2016)	CommonGround: as described above. <i>SDM aims:</i> Decisions about the use of psychiatric medication
Moncrieff, Azam, Johnson, Marston, Darton & Wood, (2016)	A Medication Review Tool was developed that intended to help patients systematically review the pros and cons of taking medication. A website was created to provide information about psychotic conditions, types of anti-psychotic medication, and points for people to consider when making decisions about medication. The Medication Review Tool can be downloaded from the website and is a form which an individual can fill in (potentially with support) prior to a medication consultation. This aims to help them express their views about medication more clearly and have their concerns addressed more systematically. <i>SDM aims:</i> Decisions about the use of psychiatric medication (specifically anti-psychotic medication)

Table 4.

Themes and subthemes across studies

Theme or subtheme	Abrines- Jaume <i>et al.</i> (2016)	Farrelly <i>et al.</i> (2016)	Goscha & Rapp (2014)	del Barrio <i>et al.</i> (2013)	Korsbek & Tønder (2016)	Deegan <i>et al.</i> (2008)	Bonfils <i>et al.</i> (2016)
Barriers to shared decision making	*	*	*	*	*	*	*
Changing roles	*	*					
Clinician exposure	*	*			*		
Power	*	*	*	*	*	*	*
Transferring of power	*			*			*
Protective withholding	*						
Mistrusting withholding		*					
Therapeutic relationship			*	*	*	*	*
Prerequisite or goal?				*			
Authenticity of the relationship			*	*	*	*	*

Note: * indicates the presence of the theme within the study.

Barriers to shared decision making.

All studies highlighted barriers to engaging in SDM reported by the perspectives of both clinicians and service users. Many of the barriers highlighted are evident in previous research such as limits on staff time, training, and resources. However there also appears to be both active and unconscious resistance acting as a barrier to the process on both sides, as discussed under the following subthemes.

Changing roles.

Despite willingness to engage with the SDM intervention, there appeared to be a struggle in some cases to deviate from the paternalistic model of decision making. Both parties entered the intervention with the pre-existing roles of 'clinician' and 'service user' and despite efforts to shift from these traditional roles, both sides struggled and would slip back into 'expert' and 'advice-seeker'. Some clinicians felt that they were 'already doing SDM' however on examination the exchange appeared more of a consultation, suggesting that there may be an unconscious shift back into the familiar role: -

...and then I say, "the other thing that needs to go in is this" and we go through it. That's it. I ask them to agree and that's it. (Farrelly et al., 2016, p. 453, *clinician discussing joint care planning*).

Service users in the Korsbek and Tønder (2016) study also appeared to struggle with adopting a more active role in decision making. Despite using a decision tool to prepare for meeting a clinician, one service user said that she "did not dare share it, as some of her considerations might be irrelevant for the staff" (p. 171). This suggests a continuation of viewing the clinician as authoritarian, and a reluctance to consider a shift from the traditional 'patient' role to feel that she is the expert in her mental health experiences within the relationship.

Clinician exposure.

Apprehension in implementing the intervention was evident across four studies (Abrines-Jaume et al., 2016; Farrelly et al., 2016; Korsbek & Tønder, 2016;

Bonfils et al., 2016) and a common theme underpinning all appears to be concern over the impact of changing practice, whereby the flexibility required has potential to expose the clinician. This would result in uncovering deficits in skill and competence: -

I think this is something pretty new that psychiatrists are coming round to in terms of offering choices. (Farrelly et al., 2016, p. 453, *clinician*).

We just had such a difficult time I think getting the prescribers on board (Bonfils et al., 2016, p.5, *clinician*).

In the Farrelly et al. (2016) study clinicians (particularly psychiatrists) largely reported negative attitudes towards the intervention, questioning its value. Limited motivation led to a half-hearted attempt and unsuccessful outcomes, reinforcing negative beliefs in the worth of SDM. As psychiatrists are often perceived as responsible for decision outcomes given their social position (Stacey et al., 2015), acknowledging uncertainty to service users or other staff may leave the clinician feeling vulnerable in their position, and potentially threaten their professional identity. Externally attributing the (expected) limited success of the intervention to the client would prevent the clinician from feeling to blame, and thus deskilled. Evidence for this suggestion is that the clinician would have been aware that their implementation of the intervention was also for research purposes, which adds extra focus on their performance. This lead to some staff dismissing the value of the intervention and their potential role within it. This is echoed within the Korsbek and Tønder (2016) study in that some psychiatrists reported that they “did not believe that Momentum [the SDM smartphone application] was relevant to them” (p. 171).

In the study by Abrines-Jaume et al. (2016) the authors report that clinicians moved between states of ‘apprehension’ and ‘feeling clunky’ before achieving the state of ‘integrated into practice’. This is suggestive of a delay in implementing the intervention due to limited confidence and skill, and limits the risk of exposure whilst the clinician learns to adapt: -

I found it difficult asking the young person to answer these questions in front of me. (Abrines-Jaume et al., 2016, p. 24, *clinician*).

The clinicians in this study were required to complete a plan-do-study-act log book to capture their implementation of SDM tools and approaches. This places the clinicians under close observation by the researchers, and may have been the driving force behind persistence of the intervention given the feelings of apprehension and 'clumsiness'. Under circumstances whereby researcher pressure is non-existent there may be the risk of clinician avoidance to limit feeling unskilled.

The apprehension and negative attitudes appear to serve a protective function by allowing clinicians to stall or disengage with the intervention, which thereby reduces the risk of clinician exposure. Lack of confidence in abilities and the limited success is a key factor in driving ambivalent approaches to SDM, and can lead to a depersonalised effect on care for the service user.

Power.

One of the key outcomes for SDM is for the service user to feel empowered by having opportunity to exercise choice and control over their treatment. All studies made reference to empowerment; or disempowerment in one case (Farrelly et al., 2016). Through reciprocal translations it became evident that in order for empowerment to occur there is a requirement on the clinician's behalf to permit power. Motives behind reluctance in permitting power differ across contexts.

Transferring of power.

Three studies including service user perspectives found that those who had taken part in the intervention felt a sense of empowerment in terms of gaining autonomy and control over decisions about their treatment (Goscha & Rapp, 2014; del Barrio et al., 2013; Deegan et al., 2008): -

It means being able to make your own decisions, make your own choices, and have a vision of the thing other than just this little magic

pill... It gives you back power over your life. Once you realize[sic] you are able to make decisions you've taken a major step forward. (del Barrio et al., 2013, p. 2883, *service user*).

Positive attitudes towards service user empowerment was also evident for clinicians within four studies (Goscha & Rapp, 2014; Korsbek & Tønder, 2016; Abrines-Jaume et al., 2016; Bonfils et al., 2016). Clinician positive attitudes appear to be fundamental to the process of transferring power, as evidenced in the Farrelly et al., (2016) study whereby negative attitudes resulted in an unsuccessful intervention and feelings of disempowerment from service users: -

I sort of felt to myself now that you know, well what can I do about it – I can't really change my team. I can't really change their decision, they're qualified... so it's their decision. I can't really do much about it to be honest. (Farrelly et al., 2016, p. 454, *service user*).

These feelings of disempowerment are reported to damage service user trust in their clinician and themselves, and appear to instil feelings of hopelessness that are historically associated with informal coercion in mental health treatment (Linhorst, 2006).

Achievability of true shared decision making.

The authors present positive outcomes in the Korsbek and Tønder (2016) study but also question whether tools to aid SDM may in fact continue to perpetuate the active-passive interaction between clinicians and staff. Service users may engage with the intervention by adopting the role of a “good client” and doing as they are asked. This desire may also be driven by the wish to avoid conflict, and wanting the clinician to be “on your side” (Joseph-Williams et al., 2014) which leads to questions regarding the extent to which true SDM can be achieved. It is inevitable that prior knowledge of SDM, and being the party who will introduce the intervention will place the clinician in a role of authority. Attempts to manage this may be facilitated by clinicians setting the scene for the SDM process in terms of roles and expectations, in order to keep the service user fully informed of their rights and options.

Protective withholding.

Clinicians working in Child and Adolescent Mental Health Services (CAMHS) appear to withhold power as a form of protection: -

CAMHS professionals tend to be understandably protective of young people and SDM may have seemed to contain risks, thereby making them hesitant to try something different". (Abrines-Jaume et al., 2016, p. 23, *authors*).

Reluctance in granting power in this context appears to stem from the preconceived belief that young people may not have the capacity to make appropriate decisions about their care.

Mistrusting withholding.

Clinicians within the Farrelly et al. (2016) study were more explicit about their reluctance to hand over power, citing that service users may not make appropriate choices, and the service will be unable to meet their requests: -

And also, there are things that the service user will want and request and you know it's not really what they need. (Farrelly et al., 2016, p. 453, *clinician*).

Yeah we can ask you what your needs are and what you want to happen, but essentially this is what we do, this is what we can do, and this is what will happen should you ring up. (Farrelly et al., 2016, p. 454, *clinician*).

Attitudes and organisational limitations therefore perpetuate the withholding of power. Reluctance in permitting this power may be underpinned by different motives, yet results in limited opportunity for the service user to adopt a more active approach in decision making.

Handler (1996) found that empowerment is very context dependent and is highly reliant on the stability of relationships integral to empowerment, the

continued availability of resources, and on the needs of those in power. Empowerment of those considered vulnerable is therefore fragile, and may be affected by the changing context in which empowerment occurs. This consideration highlights the concept of service user empowerment in SDM as very dependent on clinicians' approach to the intervention. Whilst the SDM aspect aims to be collaborative; there appears to be heavier responsibility on the part of the clinician to allow empowerment to occur.

Therapeutic relationship.

Issues relating to the therapeutic relationship were present in five studies (Goscha & Rapp, 2014; del Barrio et al., 2013; Korsbek & Tønder, 2016; Deegan et al., 2008; Bonfils et al., 2016). The therapeutic relationship has been considered an important driving force behind successful outcomes within mental health treatment (Norcross & Wampold, 2011) therefore factors which strengthen or damage the relationship are important within SDM.

Prerequisite or goal?

Service users in one study described the SDM intervention as having “transformed their relationship with healthcare clinicians – particularly prescribing physicians” (del Barrio et al., 2013, p. 2883). Increased communication is generally viewed as a positive outcome of many of the interventions: -

Another thing that comes out of that place is to where a person does begin to talk and engage with specialist because they are feeling comfortable [*sic*] (Bonfils et al., 2016, p.4, *clinician*).

In other cases, however it appears that engagement with the intervention was determined by the quality of the pre-existing relationship. Two studies report that the relationship was essential for easing service user concerns about the intervention, and encouraging them to engage (Korsbek & Tønder, 2016; Goscha & Rapp, 2014): -

If we say here is something we think can be a really good thing for you, they listen to it (Korsbek & Tønder, 2016, p. 170, *clinician*).

This suggests that at some level, an established therapeutic relationship is required for an effective SDM intervention. This appears to be driven by established trust in the clinician, which increases the service users' confidence in their ability to engage in SDM. A pre-existing relationship however may mean that both parties naturally fall into a paternalistic relationship, making it difficult to then shift into SDM due to the barriers highlighted above.

Authenticity of the relationship.

Five studies reported an improved therapeutic relationship and increased trust and communication as a result of the intervention (Goscha & Rapp, 2014; Deegan et al., 2008; Korsbek & Tønder, 2016; del Barrio et al., 2013; Bonfils et al., 2016). On closer examination however, the authenticity of these relationships is questioned as to whether certain decision aids improve or actually hinder the relationship. It was noted in two studies that disclosure of information increased (Goscha & Rapp, 2014; Deegan et al., 2008): -

I wouldn't talk as much or say as much. They wouldn't get as much information out of me (prior to CommonGround) ... once I tell the computer what my situation is and they discuss it with me... that has helped. (Goscha & Rapp, 2014, p. 270, *service user*).

It is much easier to tell the computer. (Deegan et al., 2008, p. 605, *service user*).

The authors interpret this as an increase in trust, and therefore an improved relationship. A reliance on technology to enhance the relationship however may be suggestive of a move towards a dehumanized approach, in that the relationship cannot flourish solely on the basis of human interaction. This questions the authenticity of the therapeutic relationship between the two parties. The intervention in which the clinician-service user relationship is described as “transformed” focuses on “making room for dialogue” with

supplementary information resources available, rather than a reliance on a computer-based intervention (del Barrio et al., 2013): -

Gradually, a mutual recognition of their respective areas of knowledge develops, which creates room for negotiation and for making decisions that can be qualified as shared. (del Barrio et al., 2013, p. 2883, *authors*).

These findings suggest an interplay of the collaborative intervention both potentially strengthening the therapeutic relationship, whilst in some respects requiring that some level of relationship is already established. Perspectives indicate that the therapeutic relationship may especially be enhanced when the intervention is driven by aspects focusing on dialogue rather than interventions based on technology.

Line of Argument Synthesis

A line of argument synthesis aims to collate findings from individual studies and provide an interpretation (Noblit & Hare, 1988). By synthesizing clinician and service user perspectives of engaging in SDM interventions, potential explanations are uncovered as to why the much advocated 'collaborative care' mental health services aspire to can struggle to play out in reality. Clinicians appear to both advocate SDM yet struggle to put this into practice, as adjusting the power dynamic within the relationship is associated with risks of uncovering a deficit in clinician skills, allowing the service user to make 'poor' choices, not being able to meet service user requests, and a worry that as a young person they aren't ready for the responsibility. Furthermore, the pre-determined roles that people employ (as 'service user' or 'clinician') appear to loom over the therapeutic relationship despite best efforts in creating equality. Hesitancy from clinicians coupled with the difficulty in role change seems to lead to a situation whereby both parties are attempting to engage in SDM but are stuck in the paternalistic relationship. Examining perspectives has uncovered priorities for improving the success of SDM interventions as outlined below.

Discussion

The meta-ethnography aimed to appraise and synthesize existing qualitative research into clinician and service user perspectives of SDM interventions. By examining first hand perspectives, the review has highlighted potential implications for clinical practice and future research.

Several barriers that have previously been identified in regards to SDM were present in the review, suggesting that some difficulties prevailed despite the intervention. The aim was not to specifically identify barriers, but the examination of perspectives uncovered that this was an important element of what participants said. Clinicians' concern about their competence and the threat to clinician identity as a barrier is largely absent from previous research. Effective approaches to SDM interventions are also currently unidentified, therefore consideration of how decision aids may affect authentic therapeutic relationship is useful in developing future interventions. A particular difficulty highlighted in the review was in shifting from the paternalistic model, which is congruent with previous research on barriers (Joseph-Williams et al., 2014). This can be understood in terms of social role theory, in that individuals are believed to act in line with socially defined categories to which they identify. Social roles outline a set of behaviours and norms that a person fulfils (Koenig & Eagly, 2014). The roles of 'client' and 'service user' hold a set of expectations about how a person within these roles will act, therefore increasing the difficulty of behaving in an unexpected manner as SDM proposes.

Overall, findings suggest that clinician confidence and attitudes are fundamental to the effective implementation of SDM. It is helpful if there is an established relationship between both parties prior, and interventions appeared to best strengthen the therapeutic relationship when the focus was on dialogue as opposed to computer-based aids.

It is through examining perspectives that priorities can be identified in which to drive forward interventions within healthcare (Evans, 2002). In terms of future recommendations, thorough training may support clinicians in understanding the aims and proposed benefits, in order to facilitate motivation towards the

intervention. Clinical supervision may also provide a forum of support for clinicians in allowing a safe space in order to explore motivations and apprehension in their willingness to transfer power and share decision making (Clouder & Sellars, 2004; Stacey et al., 2016). To minimise service user deference to authority, it may be required for the clinician to initially adopt a more active role during the initial building of the therapeutic relationship, whilst trust is established (Patel, Schnall, Little, Lewis-Fernández, & Pincus, 2014). This also creates opportunity to 'set the scene' and openly discuss roles and expectations within the relationship. Once this has occurred, the clinician is in a position to permit power to the service user, and may regularly engage in reflective practice (and supervision) in order to consider the SDM process and whether roles have unconsciously shifted back into a paternalistic model. During the early stages whereby an initial relationship is being established it may also be beneficial for open dialogue in regards to influential factors that may impact the SDM process, including a perceived hierarchy, to promote transparency and attempt to balance the power (Stacey et al., 2016).

Future research may wish to compare the outcomes of different SDM interventions. Findings from the current review suggest that interventions focused on increasing dialogue may support an authentic client-service user relationship. This is not to say however that technology-based interventions are inappropriate, as an increase in collaboration can still be perceived as a positive step for individuals who may otherwise have adopted a passive role. An individualised approach to SDM may be necessary in terms of supporting the service user to collaborate in the means they are most comfortable with, which is congruent with the notion of offering choice and allowing the service user to make decisions about their care.

As decision made in mental health treatment can often involve a restriction of liberty, previous research has suggested that some service users may distance themselves from decision making as to avoid accepting responsibility for these decisions (Stacey et al., 2016). This was not evident within the review, however all interventions took place within community settings therefore findings may have differed within inpatient services where a lack of choice may be more

prominent. Future research may also consider differences in implementing SDM across a wider variety of contexts.

Limitations

A potential limitation of the current review is that studies were geographically diverse, and included a range of healthcare settings and interventions. The participants sampled also had varying mental health concerns. Whilst the heterogeneity allowed for a wide range of experiences to be considered, study findings are therefore limited in generalisability. Inclusion of heterogeneous studies however has been identified as fundamental in determining higher order interpretations in meta-ethnography (Britten et al., 2002).

Due to the lack of transparency of some studies (in terms of lack of reflexivity or minimal use of original data to support findings), the influence of the authors on their conclusions could not be determined in all cases. Some studies were not open about their method of analysis; the extent to which the interpretations generated from the synthesis are supported by primary data is therefore unclear.

The review looked at clinicians as a whole, however within a staff team hierarchies will likely pre-exist based upon training, responsibility, and perceived power (Mason, Williams, & Vivian-Byrne, 2002). A limitation of the review is the inability to largely distinguish clinician perceptions by occupation. Future research may consider SDM in terms of different occupations.

Conclusion

On the whole, service users reported positive feedback in regards to SDM interventions. This suggests that despite the aforementioned barriers and question of truly achieving SDM, the offer of collaboration is met favourably. SDM interventions may be effectively implemented by supporting clinicians via training and supervision, emphasising the importance of establishing an initial relationship, 'setting the scene' for SDM, and focusing on dialogue to build the therapeutic relationship.

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Journal Paper

Do Clinical Psychologists Have a Role in Clients' Use of Psychotropic Medication? A Mixed Methods Investigation Exploring Current Forms of Involvement

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Abstract

Objectives: This study aimed to explore whether clinical psychologists in the United Kingdom (UK) have a role with their clients' psychotropic medication by exploring forms of involvement undertaken, and decision-making behind involvement.

Method: A mixed methods design was employed; 147 clinical psychologists took part in an online survey, and 11 respondents were interviewed, selected using intensity sampling. Descriptive statistics, logistic regression, and thematic analysis were used to analyse the quantitative and qualitative data respectively.

Results: All respondents reported having some role with their clients' psychotropic medication. A thematic map diagram was created to capture the process of how clinical psychologists choose to become involved.

Conclusions: Consensus was reached in that clinical psychologists do have a role with their clients' psychotropic medication, although this varies by clinician and takes on many forms. In light of the changing role, professional guidance would help to promote clarity and consistency.

Keywords: psychologists, psychotropic medication, psychiatric medication

Background

Psychotropic Medication and the Medical Model

Psychotropic medication¹ refers to drugs capable of affecting the mind, emotions, and behaviour which are commonly prescribed for the treatment of 'mental illness' (Moncrieff, 2009). Medicalised treatment is underpinned by a biological understanding of mental health problems which proposes that medication may reverse or stop an effect or alter some form of 'chemical imbalance' in the brain. The prescribing of psychotropic medication works in accordance with the model of diagnosis; an individual suffers from a medical illness and is treated primarily by medication (Johnstone, 2014). The dominance of a diagnostic model akin to physical disease minimises psychosocial factors contributing to distress, and over-emphasises biological interventions such as psychotropic medication (Boyle, 2013; Cromby & Harper, 2013). Existence of a drug to treat a specific disorder increases plausibility of a diagnosis, and drug marketing is strengthened if there is a known specific disorder to target (Moncrieff, 2009). This creates a shared view of the importance of psychotropic medication and diagnostic categories to justify their use (Cosgrove & Wheeler, 2013).

The notion of diagnosis is frequently contested and is increasingly attracting critique, particularly from the clinical psychology profession. The Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) published a position statement in 2013 advocating the need for psychological formulation and highlighting flaws in current diagnostic classification systems (Division of Clinical Psychology, 2013). Following this, The Power Threat Meaning (PTM) Framework (Johnstone & Boyle, 2018) was created to further challenge medicalisation by providing an over-arching structure for formulation as an alternative to diagnosis. Whilst noted as beyond the scope of the PTM framework, it is acknowledged that adherence to the principles may likely lead

¹ Throughout the article the term 'medication' is sometimes used to avoid repetition. This continues to refer to psychotropic medication unless otherwise specified.

to reduced levels of prescribing (Johnstone & Boyle, 2018)². As such, a secondary effect of the work around diagnosis may influence psychotropic medication. There is an established professional movement away from diagnosis, and a clear relationship between diagnosis and psychotropic medication. The question remains as to whether the professional movement with diagnosis extends into any role with psychotropic medication, be this a critical stance or any other.

Psychologists and Psychotropic Medication

What is currently known about involvement?

There is little research exploring the relationship between clinical psychologists and medication; extant research primarily focuses on attitudes towards gaining prescription privileges and is conducted outside of the United Kingdom (UK). A study by VandenBos and Williams (2000) explored roles outside of prescribing during which 596 psychologists in the United States (US) were surveyed about different forms of involvement with psychotropic medication they assumed within their roles. Based on survey findings, the researchers concluded that psychologists are extensively, albeit indirectly, involved in the process of prescribing and managing client's psychotropic medications. It was additionally speculated that the average psychologist may not be fully aware of the extent to which knowledge about, and involvement with medication already forms a significant part of their practice. Cultural differences in medical practice and the psychologists' role limits the generalisation of these findings to the UK. Similarities might be expected in UK practice but there is currently a lack of research exploring this.

Some insight into roles clinical psychologists are already adopting can be attained on a local level, such as supporting community medication groups. Medication support groups exist to help service users safely withdraw from medication, or think through broader aspects of medication use. For example, the Nottingham Mind Medication Group includes clinical psychologist support, and provides a forum for peer support and access to knowledge about

²All authors included in reference list but not in the main text as requested by authors.

psychotropic medication (Nottingham Mind Medication Group, 2013). The group does not advocate that medication should not be used, but aims to support access to information about medication. The group was developed with help and support from other similar groups, suggesting similar initiatives may be occurring yet not widely recognised.

Debates and controversy.

Despite little research, debate on the topic is by no means new, with longstanding publicised discussions on the appropriateness and ethicality of psychologists' involvement, stemming from discussing medication up to prescribing. In the US, debate around psychologists discussing medication with clients was considered following an incident whereby a psychologist was accused of "practicing medicine without a licence" after supplying a young client's father with information on the safety and efficacy of a specific medication (Littrell & Ashford, 1995). The authors highlighted that there are numerous scenarios in which psychologists might be queried about medication, yet no clear precedents in regards to how they might ethically respond. Since this time some States have adopted prescription privileges for psychologists, enabling psychologists to prescribe by completing further training. The debate on psychologists prescribing has also extended to the UK, where this remains a controversial issue dividing opinion (British Psychological Society, 2003).

In addition to cautioning the use of diagnosis, there has been critique from clinical psychologists about psychotropic medication (Kinderman, 2014) with the underlying message of encouraging a shift away from its use in practice by adopting a similarly critical stance. In a recent DCP Forum article, Houghton (2016) anecdotally proposes a number of roles clinical psychologists might undertake which are not limited to solely challenging medication use from a critical position, but opening up wider discussions to inform client decision making. Examples include: encouraging those wanting to come off medication to gain appropriate support, exploring the psychological meaning of taking medication, and providing a balanced perspective to the dominant medical discourse. The author argues that it is incumbent on the profession to raise ethical and clinical issues surrounding psychotropic medication use, and

avoidance of doing so may result in a disservice for clients. As discussed, there are a variety of views represented across the profession in regards to prescribing and wider forms of involvement (British Psychological Society, 2003, 2018; Houghton, 2016). However, the extent to which such discourses influence clinicians practice remains largely unknown.

Drivers for involvement.

Increasing public domain campaigns about the use of psychotropic medication serve as an additional driver for the research, for example, the NHS England STOMP campaign (Stopping the overmedication of people with a learning disability, autism or both) (Voluntary Organisations Disability Group, 2017). The STOMP initiative developed following a care review triggered by the Winterbourne View hospital scandal, raising deep concerns about over-use of antipsychotic and antidepressant medicines for people with an Intellectual Disability (ID) (NHS Improving Quality, 2015). Initiatives such as STOMP represent contextual factors likely to influence clinical psychologists to become involved with clients' medication, regardless of broader debates. STOMP outline aims for staff such as ensuring an understanding of psychotropic medication, including its main uses and side effects, encouraging staff to speak up if they are concerned a person may be over-medicated, and promoting psychological and person centred alternatives to medication (Voluntary Organisations Disability Group, 2017). Consequently, clinical psychologists working in ID services may be well-placed to promote such initiatives and become increasingly involved as a result of such campaigns.

Roles and professional identity.

Professional socialisation is a construct of role theory which emphasises how an individual conforms to a societally expected role (Baldwin, 2008). Clinical psychologists socialise to a professional norm in terms of professional standards set out by the Health and Care Professions Council (HCPC), DCP core competencies (Division of Clinical Psychology, 2010) and also wider expectations about what constitutes a clinical psychologist as held by the public and other healthcare professionals. Issues relating to psychotropic medication are not traditionally viewed as an aspect of the psychologist's role (Walker,

2002), and there are no fixed standards for teaching on medication within clinical psychology training programmes. As such, many clinical psychologists have perhaps historically adhered to a socially expected role which is distinct from that of a prescriber. However, there is clear advancement through members of the profession proposing potential roles and voicing critique around its use, challenging traditional ideas of professional socialisation. Alongside a lack of specific professional guidance on the matter, role ambiguity is created whereby the accepted norm for the profession is ill-defined and unclear (Baldwin, 2008). Role blurring and reduction of traditional practices has become a significant issue for many practitioners, and whilst diffusion in roles has been considered progressive and flexibly desirable, concerns of losing a sense of professional identity within the multi-disciplinary team (MDT) are also noted (Brown, Crawford, & Darongkamas, 2000). Preserving a psychologist professional identity and having involvement with psychotropic medication might be considered a juxtaposition for some, blurring the line between prescriber and non-prescriber, and potentially creating tension between professions. The above considerations are likely to leave many clinical psychologists unsure of their role with psychotropic medication, resulting in inconsistent practice when navigating decisions around involvement. It appears surprising that there is no research into clinical psychologists' roles with medication given the longstanding debates. The current research is warranted, and particularly timely given recent developments of proposing a task group to consider prescription privileges for psychologists in the UK (British Psychological Society, 2018).

Research Aims

The overall aim of this research is to investigate when and how clinical psychologists involve themselves in any aspect of psychotropic medication use with clients. It will also explore personal experiences of this involvement. The investigation will look specifically at psychotropic medication, and not medication as a whole. This is due to clinical psychologists' primary treatment focus on psychological distress (Division of Clinical Psychology, 2010), which is also the target of psychotropic medication. The research questions are:

1. What accounts do clinical psychologists provide in terms of their involvement in clients' experience or use of psychotropic medication?

2. What rationales or reasons do clinical psychologists provide for the choices they make in this involvement?’

Method

Given the paucity of literature, a mixed methods approach was deemed appropriate for complementarity in order to first gather widespread data, and then explore participant experiences in closer detail. An online survey was devised and employed, and eleven of these participants later took part in follow-up interviews. The epistemological position adopted for this research was critical realism. The position assumes that a true reality independent to observers exists; however, it is impossible to fully apprehend this reality because perceptions are framed by investigative interests and theoretical resources (Harper & Thompson, 2012). This research was granted ethical approval by the University of Lincoln Research Ethics Committee and participation was voluntary.

Instruments

An online survey was created asking participants about their involvement with their clients’ psychotropic medication and general views towards medication use. Involvement was defined as a variety of activities that have the potential to influence a change in the client’s medication regime, or may also maintain its current state. The survey was based on previous research in the field (VandenBos & Williams, 2000) and asked respondents to select forms of involvement they had used: -

- within the last six months;
- that they would do given the opportunity;
- the three they considered most important for clinical psychologists to be engaging in;
- any considered inappropriate for Clinical Psychologists to be engaging in.

A question inviting free-text responses was also included for respondents to report their general feelings on the use of psychotropic medication. The survey was piloted with trainee and clinical psychologist colleagues prior to use to test

its feasibility on a sample closely-matched to the intended audience. The survey contained an option to consent to a follow-up interview if selected. An interview schedule was created and then amended following online survey data analysis to reflect common themes. The interview schedule was similarly piloted with colleagues prior to use.

Participants and Recruitment

Online survey.

Inclusion criteria were controlled as far as possible using skip-logic within the online questionnaire and were: -

- aged over 18 years;
- qualified clinical psychologist holding registration with the Health and Care Professions Council (HCPC);
- proficiency in the English language (requirement of HCPC registration);
- working in the United Kingdom.

Targeted and opportunistic sampling was used in attempt to reach a large number of clinical psychologists. The survey was live for four months advertised online via social media, within the DCP Forum publication, and sent via email to UK Clinical Psychology training programmes and private healthcare companies employing clinical psychologists.

Semi-structured interviews.

Eleven participants who completed the online questionnaire engaged in a follow-up interview, consistent with a 'moderate' sample size as advised by Braun and Clarke (2013). Intensity sampling (Palinkas et al., 2015) was used to identify participants for recruitment from the online questionnaire who provided consent to be contacted. Selection criteria was developed to systematically choose an even mix of respondents who reported low and high levels of involvement with their client's psychotropic medication, whilst representing a variety of services. Two researchers independently scrutinized the data following agreed criteria and consensus was reached on selection. Potential participants were contacted via email and through correspondence agreed means of interview (face-to-face, video conference, or telephone).

Analysis

Descriptive statistics and logistical regression analysis were generated for the quantitative survey data was using IBM SPSS Statistics version 22. Qualitative data from the survey was coded and organised into themes (Braun & Clarke, 2006). Both data sets were combined to form a deductive framework; this provides a structure to which the researcher can systematically check for occurrence of pre-defined codes (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Semi-structured interviews were analysed using thematic analysis following Braun and Clarke's (2006) six phase guidelines. The data was read several times for familiarity, coded to capture features of the data, and then grouped into emerging themes. A dual inductive-deductive approach was adopted by doing a secondary sweep of the transcripts using the deductive framework. Identified themes were then reviewed in order to construct an explanatory framework on the basis of the most important themes (Willig, 2013).

Reflexivity

The beliefs and values of the researcher will invariably influence the approach to methodology and analysis, therefore, reflexivity is considered important to increase credibility and rigor of the research process, particularly in qualitative research (Jootun, McGhee, & Marland, 2009). A reflective diary was used by the primary researcher to record thoughts and experiences in order to reflect on how this may influence the research process. This was referred to throughout research supervision particularly during the analysis phase to maintain awareness of, and limit any bias.

Results

Sample characteristics – survey.

147 participants completed the online questionnaire (120 females, 26 males, 1 identified as other). Descriptive information about the sample can be found in Table 5.

Table 5.

Survey sample descriptive information

Years qualified	Service	Service type	Dominant psychological approach used
<5 49%	Inpatient 21.1%	Child and Adolescent Mental Health Services (CAMHS) 19%	Cognitive 2.7%
5-10 19%	Community 60.5%	Intellectual Disability (ID) 11.6%	Behavioural 5.4%
11-15 17%	Both 18.4%	Adult 44.9%	Cognitive-Behavioural 48.3%
16-20 6.1%		Older Adult 10.2%	Psychodynamic 4.1%
20+ 8.8%		Physical Health 15.6%	Systemic 4.2%
		Other³ 21.8%	Other⁴ 29.3%

³ Other service types include: Eating disorders, neuropsychology, forensic, perinatal, early intervention in psychosis, military mental health, and occupational health.

⁴ Other dominant psychological approaches used include: Acceptance and Commitment Therapy, Compassion Focused Therapy, Eye Movement Desensitisation and Reprocessing (EMDR) Therapy, Schema, and integrative working.

Table 5. cont.

Survey sample descriptive information

Completed training on psychotropic medication ⁵	Length of time since training	Professional group of trainer
No	<5 years ago	Psychiatrists
49.7%	29.3%	26.5%
<one day	5-10 years ago	Pharmacists
17%	10.2%	8.2%
One day-one week	11-15 years ago	Psychologists
23.8%	6.8%	8.8%
>one week	16-20 years ago	Other⁶
3.4%	1.4%	6.8%
Unsure⁷	20+ years ago	
6.1%	2.7%	

⁵ Either during training or post-qualification

⁶ Professional group of trainer other options: author, biologist, drug rep, nurses, self-study.

⁷ Unsure about having completed training: a long time ago in my training, as part of my doctoral training (2 days), attended talks discussing the current research and evidence base for medication for dementia, team CPD activities relating to various psychotropic medication, training delivered by psychiatrists on Dclinpsy, as part of UG teaching, few days on doctorate on impact of medication, term module at UG on psychopharmacology.

Sample characteristics – interviews.

Eleven participants from the survey took part in semi-structured interviews.

Descriptive information about the sample can be found in Table 6.

Table 6.

Interview sample descriptive information

Name ⁸	Service	Involvement
Louise	Adult	Low
Nicole	ID	High
Lucy	Physical	Low
Hannah	CAMHS	High
Hayley	CAMHS	High
Alice	ID	Low
Bradley	Adult	High
Kate	Other – Eating disorder	Low
Jessica	Other – Forensic	Low
Saffron	ID	High
Kristy	Older adult	Low

Survey Findings

The overwhelming majority of respondents (98%) reported they had recent involvement with their client's use of psychotropic medication, and all respondents reported they would be willing to have some form of involvement given the opportunity. This is despite approximately half of participants (49.7%) not having attended any specific training related to psychotropic medication. The most common form of current involvement was reflecting with a client on their general experience of taking psychotropic medication, followed by discussing psychotropic medication issues within individual client sessions, and supporting clients to discuss their psychotropic medication with their prescriber. A high proportion of participants (89.1%) responded that given the opportunity they would engage in a collaborative discussion to help a client make a decision

⁸ Pseudonym used

about their psychotropic medication, which was also reported as the most important form of involvement, despite this not being one of the most frequent forms of involvement for participants within current practice. Recommending or requesting specific psychotropic medication was perceived as inappropriate by just under half of participants (49%). Table 7 details the forms of involvement voted as most important in ranked order in response to which three were considered most important to the role. Further frequencies can be found in Table 8; responses are ranked in order of frequency regarding the question “What kinds of involvement have you had with psychotropic medication in the last six months?”, with corresponding responses to the remaining two questions listed alongside. Numerical data refers to the frequency that the option was selected and the corresponding percentage.

Logistic regression analysis found that participants working in Child and Adolescent Mental Health Services (CAMHS) ($OR = 4$, $X^2(1) = 14.7$, $p = .018$), Intellectual Disability (ID) ($OR = 8$, $X^2(1) = 14.7$, $p = .005$), and services which fell under ‘other’ ($OR = 3$, $X^2(1) = 14.7$, $p = .024$) were statistically more likely to have been involved in the decision-making process to prescribe a service user psychotropic medication, compared to those working in adult, older adult, and physical health services. Participants working in ID services were also statistically more likely to have requested or recommended that a service user be taken off psychotropic medication ($OR = 18$, $X^2(1) = 14.7$, $p < .001$).

Table 7.

Options voted as most important

	Form of involvement	Frequency option was selected
1	Engaged in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication.	82 (55.8%)
2	Supporting service users to discuss their psychotropic medication with their prescriber	61 (41.4%)
3	Involved in the decision making process to prescribe a service user psychotropic medication	57 (38.8%)
4	Reflecting with a service user on their general experience of taking psychotropic medication	56 (38.1%)
5	Reflecting with a service user on how their psychotropic medication may affect their engagement with psychology	42 (28.6%)
6	Referral to a psychiatrist/other prescriber for psychotropic medication	39 (26.5%)
7	Discussed psychotropic medication issues within individual service user sessions	32 (21.8%)
8	Consulted with a psychiatrist/other prescriber about changing a service user's psychotropic medication	18 (12.2%)
9	Taking the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)	17 (11.6%)
10	Requested or recommended that a service user be taken off a specific psychotropic medication	12 (8.2%)
11	Supplied information about psychotropic medication to a service user	6 (4.1%)
12	Using psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects	6 (4.1%)
13	A psychological or neuropsychological assessment prompted recommendations for psychotropic medication	5 (3.4%)
14	Requested or recommended that specific psychotropic medication be prescribed for a service user	4 (2.7%)
15	Discussed psychotropic medication issues in group therapy sessions	1 (.7%)
16	None	0

Table 8.

Survey results

Form of involvement	What kinds of involvement have you had with psychotropic medication in the last six months?	What kinds of involvement would you do given the opportunity?	Are there any options you feel are inappropriate for clinical psychologists to be engaging in?
Reflecting with a service user on their general experience of taking psychotropic medication	120 (81.6%)	136 (92.5%)	0
Discussed psychotropic medication issues within individual service user sessions	117 (79.6%)	118 (80.3%)	3 (2%)
Supporting service users to discuss their psychotropic medication with their prescriber	106 (72.1%)	134 (91.2%)	1 (.7%)
Engaged in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication	101 (68.7%)	131 (89.1%)	0
Consulted with a psychiatrist/other prescriber about changing a service user's psychotropic medication	91 (61.9%)	111 (75.5%)	5 (3.4%)
Taking the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)	82 (55.8%)	122 (83%)	1 (.7%)
Referral to a psychiatrist/other prescriber for psychotropic medication	73 (49.7%)	102 (69.4%)	9 (6.1%)
Reflecting with a service user on how their psychotropic medication may affect their engagement with psychology	73 (49.7%)	128 (87.1%)	0
Involved in the decision making process to prescribe a service user psychotropic medication	65 (44.2%)	105 (71.4%)	10 (6.8%)

Table 8 cont.

Survey results

Form of involvement	What kinds of involvement have you had with psychotropic medication in the last six months?	What kinds of involvement would you do given the opportunity?	Are there any options you feel are inappropriate for clinical psychologists to be engaging in?
Supplied information about psychotropic medication to a service user	49 (33.3%)	87 (59.2%)	32 (21.8%)
Requested or recommended that specific psychotropic medication be prescribed for a service user	30 (20.4%)	49 (33.3%)	72 (49%)
Requested or recommended that a service user be taken off a specific psychotropic medication	29 (19.7%)	70 (47.6%)	39 (26.5%)
A psychological or neuropsychological assessment prompted recommendations for psychotropic medication	28 (19%)	54 (36.7%)	30 (20.4%)
Discussed psychotropic medication issues in group therapy sessions	15 (10.2%)	68 (46.3%)	9 (6.1%)
Using psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects	13 (8.8%)	61 (41.5%)	8 (5.4%)
Other	8 (5.4%)	9 (6.1%)	0
None	3 (2%)	0	49 (33/3%)

Interview Findings

The analysis identified five overarching themes, some with corresponding subthemes. The thematic map (Figure 2) has been created to capture a prominent narrative within the data of the process by which clinical psychologists' weigh up factors prior to deciding to have involvement, and then flexibly navigates their approach to and actions during involvement. This process incorporates stages (which have formed themes) and been separated for clarity, but may overlap in practice.

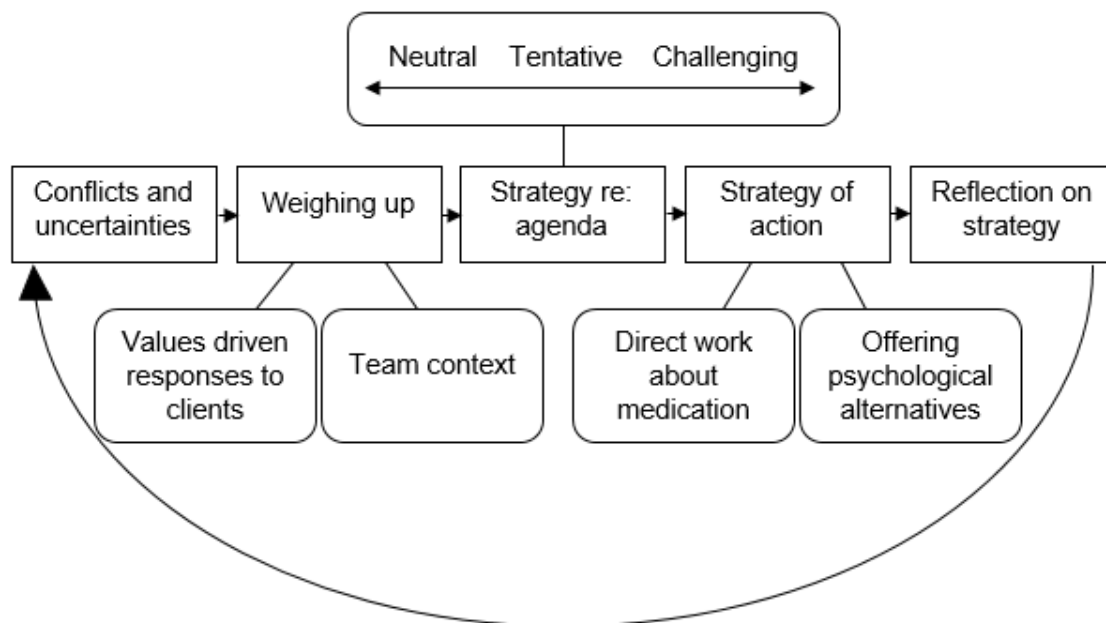


Figure 2. Process of involvement

Conflicts and uncertainties.

This theme highlights pre-existing conflicts and uncertainties that clinical psychologists face prior to making any decision about involvement. This was particularly within the context of the profession holding a broad critical stance, and what was felt as a duty to advocate against biological frameworks of mental health. The majority of participants reported strong encouragement during training to challenge the medical model, and a lack of teaching specific to psychotropic medication. This left many feeling uninformed and ill-prepared given the prevalence of medication use in practice, having to navigate the challenges of working in systems with entrenched medical underpinnings: -

“It felt as though our job, as psychologists, is to advocate for, you know, on behalf of the patient, and kind of shift away from this taxonomic DSM⁹ model, to this kind of wonderful world where everyone formulates and nobody prescribes, you know. And in practice that’s, that’s just not realistic”. - Lucy

Disparity between professional expectations and reality of practice added further conflict in terms of medication use being at odds with the dominant professional stance, with hesitancy to be too critical of a widely used treatment option that many clients and colleagues value. Uncertainty also arose in how knowledgeable participants felt they were expected to be about medication: -

“So I think there’s that dichotomy between wanting to be seen as knowledgeable and, you know, I know about medication, I can pronounce these, I know what you’ve prescribed for. And on the other hand going, well actually, I’m not a medic, I’m not a nurse, I’m not going to pretend that I have full grasp of why this person’s taking this”. - Nicole

These conflicts and uncertainties shape the context of clinical practice, with decisions being navigated in their presence. There is participant consensus about clinical psychologists having a role with psychotropic medication, but where this role begins and ends feels unclear, particularly amid perceived expectations from the profession to adopt a critical stance.

Weighing up.

‘Weighing up’ attempts to capture what seems to be an implicit process whereby participants consider a variety of factors before choosing to have involvement. Certain aspects were found to encourage or discourage involvement; these factors have been grouped under two subthemes: values driven responses to clients, and team context.

⁹ Refers to Diagnostic and Statistical Manual of Mental Disorders

Values driven responses to clients.

Prior to involvement, participants considered whether they felt able to provide information when a client appeared to be ill-informed, or misinformed about the effects of medication. A desire to provide information appeared to stem from personal and professional values of supporting informed consent. Some considered it *“part of my duty of care to my clients... to encourage them to be informed about medication”* (Hayley). There was acknowledgement that it may fall outside of role remit, but psychologists might feel driven to intervene if other professionals did not appear to provide information: -

“And in a way that’s not my role, I don’t think, it’s the GP’s role. She should have given the staff member and the client, you know, some literature about it. But because that’s not been done, I kind of feel like a pull really, to think, well you do need this knowledge”. - Jessica

Participants also described a sense of duty to explore client beliefs about what medication can achieve and to manage expectations and minimise false hope: -

“I think a lot of people think, well I’m taking this and I’ve been taking it for two months, so I should now feel at least sort of fifty percent better. And then you have to have conversations about exactly sort of what medication can and can’t do. That it’s sort of not a magic pill and that it sort of might have a, might make a slight shift, but it wouldn’t sort of fix your problem”. - Hayley

Even when driven by values, decisions to intervene were weighed up with fear of potential negative consequences of addressing medication issues: -

“I think there’s always the fear of litigation in the NHS and sort of, I’m always very cautious to make sure I stay within the boundaries of my role because if I start, even if I’d had further training, if I’m starting to advise and, you know, I think I would be worried about giving the wrong advice”. - Lucy

Weighing up may result in not becoming involved despite a values-driven desire to, due to concerns of overstepping boundaries, providing inaccurate information, appearing unknowledgeable, offending colleagues by encroaching into their area, or fear of blame and litigation.

Most participants believed medication was appropriate in some circumstances, but that it was over-prescribed and inappropriately used as a first-line treatment. A drive to challenge the use of medication and propose alternatives was, however, weighed up in practice with consideration of client distress and risk: -

“I’m just thinking, just get them calm, get them a little bit calmer, get them to be able to just not do themselves harm... I think when there’s issues of risk, it’s not going to be for me to try and stop people benefitting from something that might help them in the short term”. - Louise

This offers an example of values relating to maintaining client safety and reducing distress outweighing values that might drive critical involvement in clients’ medication.

Clients’ diagnosis and presentation also influenced whether participants considered themselves as having the authority to respond, given narratives about the aetiology of a diagnosis and whether it was considered a ‘psychological’ difficulty: -

“I have a stronger argument if somebody has a personality disorder diagnosis... because the evidence backs me up, because it’s also seen as more of a psychological issue, so I’ve got more authority to talk about it”. - Louise

Alternatively, dominant biological understandings of a diagnosis made it more challenging to offer alternative perspectives. Inclination to speak up also appeared motivated by a pull to advocate on behalf of clients when an individual

may lack capacity or present as suggestible, e.g. Nicole discussed clients with an ID: -

“Not all, you know, some will have capacity to make decisions, but are still led massively by the opinions of those around them... So it’s sometimes about they’re being very influenced, being very led, by people in the system. So I think we have more of a role to advocate for our clients”. - Nicole

This was particularly reflected in CAMHS and ID services, with values-based practice often prevailing during weighing up, perhaps due to feelings of protectiveness that a client’s perceived vulnerability may evoke.

Team context.

‘Team context’ refers to external factors that influence decision making about involvement encompassing the immediate team and set-up of the service. Participants appeared to weigh up whether they needed to be involved based on whether the MDT’s actions were already aligned with their agenda. In some instances, this meant deciding to step back as there was felt to be little need to intervene: -

“I might ask why somebody’s on something. Certainly, people who have a personality disorder diagnosis, I might say, why are they on all this stuff? But actually, usually the psychiatrist and pharmacist in the service that I work in are really hot on saying, let’s, it’s not going to help, so let’s get them off it, you know”. - Louise

This appeared particularly evident in services whereby there were national drivers for medication reduction, such as dementia and ID services, or in services where clients had additional health risks, such as older adult and eating disorder services. In deciding whether to raise an issue about a client’s medication or offer an opinion, there was often a process of weighing up whether participants felt permitted to do so in the context of a team meeting.

Good quality relationships, particularly with prescribers, were felt to be key in broaching such conversations: -

“I think it’s, we’re fortunate that the relationships, and I feel the relationships here with our medical professionals are very transparent and very honest. So I wouldn’t have difficulty saying to a medical professional in an MDT setting, well actually, it’s not helping, so we don’t want to give tablets”. - Nicole

Nicole feels confident in challenging the use of medication due to an understanding that her views will be well received or at least considered. In contrast, others reported how power dynamics could impede authority to speak up: -

“...this kind of heavy medication was suggested and I was sitting there thinking, oh my word. And so the mother turned to us, as people that, you know, were in the previous meeting with her, and just kind of, you know, was saying to us, well what do we think about that? And straightaway the psychiatrist said, I’m the only one that can give information about medication, it’s only me that you need to listen to”. - Alice

Such experiences consequently affect the weighing up process in future situations, based on expectations of receptiveness by the team.

An additional challenge was being invited to take on a role, such as an intermediary role between service user and prescriber. This created difficulty in navigating requests as role boundaries felt unclear, and there were concerns about being perceived as aligning too closely with psychiatry: -

“So I have actually, you know, had to do a bit of an assessment sometimes with a client, saying, how do you feel about your medication, do you want it to change, do you want to see psychiatry, what are your thoughts? Because they’re not engaging with psychiatry... So

sometimes that feels a bit uncomfortable but I think it's about positive working relationships, isn't it?" - Nicole

Nicole explains how taking on such a role is balanced with hoping to maintain good working relationships with colleagues, which can sometimes take precedence despite concerns about blurring role boundaries.

The service in which participants work also influences the opportunities for involvement that arise. In a service with no co-located prescriber, the psychologist may have a lead clinical role, which necessitates greater involvement with medication: -

"So yes, like if I didn't think someone needed medication, then I wouldn't refer them. And if I felt they do need it, then I'd need to refer, and if I don't have that conversation with myself, then nothing happens". - Kristy

Kristy occupies this role comfortably and offers a clear account of being solely responsible for the decision to afford service users access to medication. In this extract the weighing up process is straightforward and routinely engaged in.

Overall, participants' values-based responses to clients frequently drive involvement, but are weighed up against a variety of factors before action takes place. This includes uncertainty about knowledge held, overstepping role remit, and dynamics within the team.

Strategy re: agenda.

A decision to become involved was underpinned by psychologists' agendas towards medication, often aimed at influencing prescribing in some capacity. The strategy by which agendas were expressed varied both between and within participants depending on the situation, aligning on a continuum from neutral, to tentative, to challenging. Neutral refers to the dropping of views and personal agenda towards medication, and acting in a neutral or balanced way, whilst tentative and challenging reflect the expressing of agenda.

Neutral strategies were often responsive and used when relevant knowledge was felt to be lacking, or actions were considered out of remit. Hayley explains the reason she may choose not to express her agenda: -

"I do feel like I have reasonable knowledge about what different medications do and how they work, it's just I wouldn't want to step outside of the boundaries, as you were saying, or sort of outside of my role in talking about it too much with my clients". - Hayley

Tentative strategies to gently query and challenge medication use were used by way of *"inviting curiosity"*, *"introducing doubt"*, and *"thinking about the nudge, you know, where you might try to push people in the right direction with little things"* (Bradley). Challenging strategies risk gaining a domineering reputation, and meeting resistance. However, others believed outwardly voicing disagreement was more effectiveness in influence change: -

"...I think if you're too tentative with it, which is a lot of the time what psychologists are encouraged to be like, tentative and curious, actually, it doesn't get taken anywhere, it doesn't get taken seriously". - Saffron

Whilst the underlying agenda remained consistent, strategies in expressing this were flexibly adopted and participants moved between stages of the continuum, as Hannah explains: -

"...sometimes I've kind of just talked about the psychological approach and said, oh can you just give us a few weeks? Because otherwise, we won't be able to know whether it's the medication or the psychological work. And with other people I've kind of had more of a direct, but we don't have any evidence that this medication would work... So it depends who I'm talking to, as to how I'd approach the conversation." - Hannah

Hannah assesses the most efficient strategy to communicate her agenda and influence change. This flexibility allowed participants to remain loyal to their

agendas in spite of unsuccessful involvement, as alternative strategies are adopted and used.

Strategy of action.

The actual process of involvement with medication broadly fell under two subthemes: direct work about medication, and offering psychological alternatives. Both forms operationalise underpinning agendas by putting these into practice.

Direct work about medication.

All participants reported engaging in direct work about medication, most notably adopting a reflective role helping clients consider medication and its usefulness, and discussing the utility of medication with the team: -

“I have a therapy role and I also have a care coordination role in my team, and in both of those I would discuss medication with people if, whether that’s sort of them coming to me saying, oh I’ve been thinking about taking medication or I’m not sure about what I’m taking, you know, those kind of queries... And I do join their psychiatric reviews quite often and I’ll have conversations with the psychiatrists about whether or not medication’s likely to be helpful.” - Hayley

Additional examples include: providing information about medication side effects, suggesting or advocating use of medication, supporting decision making by weighing up pros and cons, and attending joint psychiatry reviews.

Offering psychological alternatives.

Perhaps unique to clinical psychologists, awareness of clients’ medication and its effects helped to inform psychological formulation of the individual: -

“So it can just tell you a lot about somebody’s coping at that moment in time. You can start to wonder why it is. Is it the culture of the hospital or is it because that person hasn’t got any other coping skills?” - Louise

Louise understands a client's relationship with medication as part of a formulation about their coping styles, informing possible routes for intervention.

Promoting psychological alternatives to medication was often used as a strategy for challenging medication use, an aspect considered vital within the role: -

"I think as psychologists probably we do have a role in, we have a big role in promoting psychological approaches to mental health. And sort of thinking, sort of maybe showing examples of when it can be used as an alternative to medication." - Kate

This was achieved by sharing formulations, and promoting alternative coping strategies to medication, indirectly challenging diagnosis and medical understandings of mental health. Although considered an important role, challenges of doing so were recognised. Lucy highlights difficulties faced in implementing an intervention: -

"So it was one of those, that kind of in practice, you could very much advocate for non-medication and sort of a more holistic psychologically informed intervention, but kind of actually, when it came down to it, sometimes resource levels made that not very feasible." - Lucy

Lucy's attempted intervention demonstrates ongoing difficulties faced with the application of psychological alternatives.

Offering alternatives and challenging medical narratives was also considered an aspect of the role on a wider scale by some. Alice shared critical articles about medication with colleagues with aims of influencing change by disseminating information and gaining like-minded allies: -

“So I think it’s not enough just to sit and sort of moan, you have to actually get out there and do the work and publicise it and influence wherever you can.” - Alice

Similar sentiments were echoed across participants, however, this role of challenging the status quo was felt to be at risk of being lost if psychologists gradually emerge into performing solely therapeutic roles, as Bradley believed to be the case: -

“I think as long as psychologists always put primacy on formulation and, you know, the biopsychosocial model, then, you know, just by doing that, then there will always be a challenge to kind of the more simplistic medical or biological view. But yes, there’s a risk that we could lose that if that isn’t seen as kind of like what a psychologist does.” - Bradley

A clear role for clinical psychologists promoting alternatives to medication is outlined, however, potential barriers in feasibility highlighted.

Reflection on strategy.

The final part of the involvement process entails reflecting on the strategy used and its perceived success. This feeds back into the beginning of the process whereby the outcome is viewed in context of conflicts and uncertainties (which may or may not have changed) and hence forth.

Mixed outcomes as a result of involvement were reflected, with some participants reporting *“The amount of times that I’ve been able to influence anything are tiny, you know, just a handful of times”* (Bradley), whereas others felt that *“Psychology is really valued and we are quite respected, so my view does often count”* (Saffron). Despite variation in outcome, there was general consensus that ‘unsuccessful’ involvement would not deter from deciding to become involved again in future. Hannah responds to a question about feeling discouraged when being shut down from expressing her views in a meeting: -

“No, they just really annoyed me. Because I just, I guess by that point, I just felt like I had a role and I’m employed to have this role, and I’m doing a really rubbish job if I don’t advocate a psychological approach when I’m that person’s psychologist.” - Hannah

Hannah’s reflection can be seen to link back to the ‘values-driven responses’ subtheme in that based on past experiences of involvement, she continues to weigh up decisions and is directed by values of working in line with client’s best interests. Based on experiences of being shut down she may, therefore, adopt an alternative strategy of agenda and action.

Summary of Interview Findings

Results suggest that clinical psychologists are engaging in various forms of involvement with medication on a regular basis, often with intent to influence prescribing based on their agendas. Analysis identified a process by which clinical psychologists weigh up factors prior to deciding to have involvement in order to establish their rationale, and then flexibly navigate their approach and actions. This all occurs within the context of professional uncertainty and conflict, under dominant societal narratives around epidemiology of mental health difficulties and the effectiveness of medication. Following involvement, participants reflected on their strategy which led them to consider future approaches.

Synthesis of Results

The survey data was largely supported within the interview data, particularly reflected in personal opinions towards medication. Many forms of involvement within the survey were discussed during interview, but qualitative exploration enabled increased forms of involvement to arise. Additionally, processes of decision making and strategy selection were identified which represent an important elaboration on the findings of the survey. Whilst both data sets were largely aligned, there were some slight discrepancies which will now be discussed.

Requesting or recommending that medication be prescribed or discontinued for a client was largely identified as inappropriate during the survey, but the majority of interview participants spoke of their strategies in challenging medication use. One reason for this discrepancy might be the particular phrasing of the survey option in that clinical psychologists might not advise on a “specific” medication, but more broadly. Based on the interview data, knowledge on specific medication types would likely be seen as beyond the remit, whereas all participants reported having some general knowledge. Alternatively, it may be deemed more of an appropriate role to question or challenge medication use in a preventative manner prior to it being prescribed. This was not an available option on the survey, however, was the context of many of the examples participants described. VandenBos and Williams (2000) suggested that the average psychologist may not actually be aware of the extent to which knowledge and involvement with psychotropic medication may form a significant aspect of their practice. The manner in which participants attempted to challenge or reduce the use of medication within the survey is complex and often subtler as opposed to directly voicing disagreement. As such, participants may not have considered themselves to be actively trying to reduce or stop the use of medication, possibly explaining the discrepancies between data sets.

Client vulnerability and possible lack of capacity prompted some participants to seek an advocacy role and feel increased empowerment to take on a role with clients’ medication. This offers context to the survey finding that participants working in CAMHS and ID services were more likely to be involved in decision-making processes, and participants working in ID were more likely to request or recommend a client be taken off medication.

Discussion

Findings echo those of the US study by VandenBos and Williams (2000), who found that almost all psychologists in their study were involved with medication in some capacity. Current forms of involvement are also congruent with roles proposed by Houghton (2016), indicating that hypotheses around what the remit of the role might be are already occurring in practice. In addition, clinical

psychologists' roles extend beyond those proposed by Houghton (2016), demonstrating more of an active and challenging role than might have been expected. These findings have clinical implications given that by and large, clinical psychologists are regularly engaging in roles with psychotropic medication despite a lack of guidance from professional bodies, no professional position statement, and minimal (or no) teaching during training.

Vandenbos and Williams (2000) offer little speculation of agendas driving involvement other than suggesting that knowledge of medication may help in understanding the whole person, and support career progression into new roles. In the current study, participants' involvement was both driven and justified by the belief that it was integral for remaining loyal to personal and professional values. Agendas propelling involvement can be understood within the key values underpinning the profession, outlined in the code of ethics and conduct: respect, competence, responsibility, and integrity (British Psychological Society, 2009). Participants navigated their actions within their boundaries of competence by intervening to uphold their responsibility to reduce clients' psychological distress. Ensuring client self-determination by claiming to support informed decision making, and managing expectations of medication in clients' 'best interests' can be framed under the values of respect and integrity. The notion of intervening in clients' best interests raises interesting issues, however. With absence of a formal capacity assessment to determine a best interest decision in its true definition (British Psychological Society, 2010), this reflects a parallel idea to 'best interests' whereby own views are imposed with assumption of knowing best. This highlights the question of whether involvement is genuinely within clients' interests, or is driven by a series of personal, professional, and broader societal agendas.

Within context of emerging critical publications towards the medical model (Johnstone & Boyle, 2018), it was anticipated that findings might represent a largely critical stance erring away from supporting medication use. In contrast, participants experienced conflict arising from perceived pressure to advocate away from medical approaches, with challenges faced applying this in practice. Indeed, most participants were opposed to professional critical narratives and

took care not to adopt these into practice. The body of participants does not appear to be representative of the alleged professional view, raising the question of whether the profession does in fact hold a collective critical stance, but just some vocal members within it.

Comparisons can be drawn with a recent study exploring clinical psychologists attempts of working beyond diagnosis (Randall-James & Coles, 2018). The authors found that many psychologists “played the diagnosis game” in order to pursue change, and sought balance of getting along with others whilst negotiating differences to make small changes. Similarities can be found in that clinical psychologists also factored in the team context when weighing up decisions to be involved. However, Randall-James and Coles (2018) found that the action of making a stand and voicing difference was found to be courageous or troublesome by clinical psychologists in their study, a concept not reflected in the current study. This discrepancy is interesting given the professional stance and guidance on diagnosis (Division of Clinical Psychology, 2013; Johnstone & Boyle, 2018), but not on psychotropic medication. This might perhaps be due to psychotropic medication being one aspect of clients’ treatment, whereas questioning diagnosis potentially challenges larger understandings and frameworks of mental health. In addition, negative consequences of medication could be more apparent when compared to those of diagnosis, increasing the rationale for challenging its use.

Role ambiguity was apparent within the current study as all participants noted a clear role with psychotropic medication, but difficulty in judging these parameters. To a large extent, team context impacted decisions around involvement and influenced how participants shaped their role. Difference in authority, power and status have been found to limit a professional’s capacity to influence their team (Onyett, 2003), reflected in the findings by some who felt disempowered to become involved. Research into MDT working suggests that two alternative professional reactions are generally elicited by members; firstly, attempts to establish marked inflexible roles based on professional expertise, ensuring that professional interests do not overlap (Hannigan & Allen, 2011; Peck & Norman, 1999). This has been found to be particularly pronounced

when clinicians found themselves 'feeling threatened' by other professions (Donnison, Thompson, & Turpin, 2009). This may account for power dynamics impeding psychologists' involvement due to perceived encroaching into psychiatry's domain.

Secondly, professionals may allow role blurring to occur when there is a shared body of knowledge (Onyett, 2003), resulting in disorganised role boundaries and overlapping responsibilities between professionals (Bailey, 2012). Role blurring was most apparent where professionals' task boundaries were flexible, such as fulfilling an intermediary role between the psychiatrist and client. Some participants described feeling pulled into intervening beyond their remit to fill gaps missed by other professions. Role blurring has been found to impact the division of labour on teams (Maddock, 2015) and result in reduced team efficiency (Wall, 1998). Role ambiguity, therefore, has implications for effective team working but remains an unresolved issue given the current lack of consensus and clarity on roles with medication.

Limitations

It is important to consider the potential impact of self-selection bias; those with strong opinions on the use of psychotropic medication may have increased interest in voicing their opinions. However, attempts were made to minimise this risk through recruitment. The spread of responses in reply to being questioned about strong views in the survey, and balance of views within interviews suggests that this was at least in part successful.

Generalisability

Participants were recruited from a variety of services in order to facilitate comparison and increase transferability. The critical realists' aim is not to generalise, but to develop deeper levels of explanation and understanding regarding the phenomenon under study (Mcevoy & Richards, 2006).

Furthermore, there is debate as to whether generalisability is a meaningful goal for qualitative research (Braun & Clarke, 2013). Goodman (2008) proposed a concept of flexible generalisability which may be claimed when a discursive strategy achieves a certain function, and the strategy achieves this function in a

range of settings by a range of speakers. Study results support a claim of flexible generalisability, as analysis indicated a shared process underlying decision making (despite variety in actual forms of involvement) across both participants and service types. In addition, interviews largely supported survey findings, suggesting that participants interviewed are likely to be reflective of the wider sample (increasing generalisability claims).

Clinical Implications and Future Directions

To the author's knowledge this is the first study to explore the topic area within the UK. Study findings are considered important due to uncovering the extent to which involvement forms part of the role, which was previously unknown. Findings translate into two main clinical implications: 1) supporting the idea of training on psychotropic medication for clinical psychologists, and 2) professional guidance to inform clinical psychologists' practice.

Houghton (2016) suggests that a position statement on psychotropic medication could be created in a similar vein to the DCP statement on diagnosis (Division of Clinical Psychology, 2013). Such a statement may balance some of the debates around medication use and the biological model of mental health, as well as support helpful prescribing. The current research supports Houghton's proposal. Guidance and/or a position statement would serve to back clinical psychologists in their roles with medication, propose boundaries to help navigate decisions, and instill confidence in authority to talk about medication. As it stands, clinical psychologists are already involving themselves, therefore, professional guidance may help inform consistency and support individuals through the weighing up process who may previously have felt that the issue was unrelated to their role. Participants working in ID services felt particularly driven to advocate on behalf of clients due to perceived vulnerability and issues with capacity. This may reflect the impact of initiatives such as STOMP, suggesting how formal guidelines might permit greater involvement.

VandenBos and Williams (2000) called for a generally agreed model of psychopharmacology training for psychologists to support them in understanding how psychotropic medication use can affect their clients, and to

increase ability to move into different employment positions (such as directors of inpatient hospitals). Participants in the current study had mixed views on whether they thought training should be received. Many felt that increased knowledge would be helpful, whereas others were unsure about the expectations this would create for psychology amid fears this would blur the profession with psychiatry. Nonetheless, perhaps increased focus on psychotropic medication during training would be relevant considering the extent to which medication already forms part of the role for many.

There may also be increased relevance for training on psychotropic medication post-qualification, especially considering changing roles for clinical psychologists. The mental health workforce plan for England produced a document: Delivering the Expansion in the Psychological Professions (The Psychological Professions Network Alliance, 2018) outlining plans for mental health care forwards to 2020/21. Future opportunities note the idea of 'flexible practice' in that psychological professions are well placed to take up roles that have been traditionally held by psychiatrists. This includes Responsible Clinician (RC) roles wherein responsibility is taken for the whole of a person's care where they may be detained under the Mental Health Act. Adopting such roles may call for increased awareness of psychotropic medication, and increased involvement with decisions about medication. In addition, as of January 2018 the BPS are seeking to create a task group to consider prescribing rights for psychologists. The intention is to increase the range of specialist support services that psychologists can offer, rather than replicating the expertise of other healthcare professionals (British Psychological Society, 2018). This highlights the ongoing debate of clinical psychologists and psychotropic medication, further emphasising the need for clarity on roles and expectations.

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Extended Paper

1. Extended Background

This section expands on the journal paper by providing further information on relevant literature, additional theory to support the research, and extended rationale for the study.

1.1 Psychotropic Medication¹⁰ and the Medical Model

Psychotropic drugs are the mainstay of psychiatric treatment, and have been since about the 1950s (Moncrieff, 2009). Prior to this time, drugs (particularly sedatives) were used in psychiatric hospitals, however, as new drugs were introduced, views about how they worked gradually transformed. An understanding developed that the drugs worked by reversing underlying psychiatric diseases akin to physical illness. As a branch of the medical profession, psychiatry has historically conceded that psychological distress can be understood and treated with drugs, not unlike physical health problems (Moncrieff, 2009). Although this view has also constantly been challenged, the 1960s saw an antipsychiatry movement whereby philosophical and political objections arose against the concept of psychiatric disorder as a medical illness (Szasz, 1970). Despite contestation of the medical model, biological explanations for the causation of mental health problems and ensuing diagnostic categories perpetuated the widespread use of drug treatments. The development of a market for specific drugs has also served to shape views about the nature of disorders, and in some cases permitted creation of such diagnoses in order for drugs to seemingly target specific disorders. As an example, the concept of depression was not widely accepted prior to the introduction of drugs considered to be antidepressants (Moncrieff, 2008). Consequently, the pharmaceutical industry has been influential in shaping the course of psychiatric treatment.

Interpreting the evidence base for psychotropic medication presents a complex picture, given the vast array of drugs and diagnostic categories of mental health disorders subject to research. Taking antidepressants as an example, there are numerous randomised control trials comparing the efficacy of antidepressants

¹⁰ Throughout the article the term 'medication' is sometimes used to avoid repetition. This continues to refer to psychotropic medication unless otherwise specified.

with placebos in individuals who have been diagnosed with depression. Overall, most studies report better outcomes for those taking the antidepressants, however, many studies find no difference and often the size of the effect is very small (Moncrieff, 2009). Consensus on the efficacy of psychotropic medication has not been reached and remains a contentious issue; a recent systematic review determined that antidepressants were indeed more effective than placebos (Cipriani et al., 2018), a conclusion reaching newspaper headlines (Bosely, 2018) despite previous weak evidence (Moncrieff, 2009). Regardless of limited evidence for a disease model of mental health (Moncrieff, 2009), and mixed evidence for the efficacy of psychotropic medication, prescription rates continue to increase. Figures demonstrate a 6% rise in the prescription of antidepressant medications in the community in England between 2015 and 2016 (Health and Social Care Information Centre, 2017). This increase is consistent with the overall rising trend for all psychotropic medication, which rose on average by 6.8% every year between 1998 and 2010 (Ilyas & Moncrieff, 2012). Psychotropic medication remains a core component of modern psychiatric treatment, recommended within National Institute of Health and Care Excellence (NICE) guidelines for many psychological problems, e.g. depression (National Institute for Health and Care Excellence, 2016) and obsessive compulsive disorder (National Institute for Health and Care Excellence, 2005).

1.2 Clinical Psychology and the Medical Model

As outlined in the journal paper, there is a long history of movement within the Clinical Psychology profession advocating for a shift away from use of the medical model framework of mental health. This is most apparent in regards to psychiatric diagnosis. The British Psychological Society (BPS) propose that psychologists may use evidence-based psychological formulations, theories, and models as a means of supplementing or replacing diagnosis (Division of Clinical Psychology, 2011). Furthermore, a position statement was published outlining a collective professional view on diagnosis, and how a paradigm shift was needed to incorporate psychological formulation into mental health care (Division of Clinical Psychology, 2013). Recent research into clinical psychologists' questioning diagnosis in practice suggests that attempts to create a paradigm shift are occurring by way of making small changes to

practice and sharing psychological alternatives (Randall-James & Coles, 2018). However, this practice was reportedly met with difficulty, as participants suggested a need to work with diagnosis due to the utility it can hold for the client, or to maintain working relationships. The authors concluded that an alternative conceptual framework for non-diagnostic practice was needed to support psychologists in working beyond diagnosis. Since publication of the research, the Power Threat Meaning Framework (PTM) has been issued in an attempt to offer such a conceptual framework (Johnstone & Boyle, 2018). Subsequently, continued research into psychologists influencing a shift from the medical model may be anticipated in future.

A small number of professional publications make reference to psychotropic medication, however, consideration remains somewhat limited. The Division of Clinical Psychology (DCP) document 'Understanding Psychosis and Schizophrenia' considers psychotropic medication use (Division of Clinical Psychology, 2014). The document outlines both helpful and harmful effects of medication, challenges the use of medication under compulsion, and states a need for services to move beyond the medical model. Additionally, the PTM framework also encourages professionals to be aware of the potentially damaging effects of psychotropic medication, and how their use may cause or exacerbate emotional distress (Johnstone & Boyle, 2018).

1.3 Psychologists and Psychotropic Medication

This section will expand on the literature review in the journal paper by describing the literature search strategy, elaborating on previous research, including relevant additional papers, and justifying exclusion of attitudinal research papers

1.3.1 Literature search.

A literature search was conducted using a combination of the search terms “psychologist”, “medication”, “psychotropic”, “psychiatric” and “prescribing”. Papers were screened regarding their relevance to the research. A collection of papers returned from the search were both commentary and research articles exploring attitudes towards psychologists gaining prescription privileges in a

variety of countries. For example, questioning whether psychologists in New Zealand supported the idea of prescribing (Fitzgerald & Galyer, 2008), considering the pros and cons of psychologists prescribing in the UK (Newman, 2013), and advocating against prescribing in the US (DeNelsky, 1996).

A decision was made to exclude attitudinal papers in order to maintain 'involvement' in a broad sense and avoid a narrow focus specifically on prescribing. Additionally, whilst it was anticipated that opinions on broader roles and prescribing may emerge during interviews, the research questions focus on what roles clinical psychologists are currently adopting as opposed to contributing to the ongoing debate around gaining prescription privileges.

1.3.2 International research.

Extant research on psychologists and their involvement with psychotropic medication has predominantly been conducted in the United States (US). This is likely given the debated Prescriptive Authority for Psychologists (RxP) movement, as there are currently three States in which psychologists can undertake further training to gain prescription privileges (American Psychological Association, 2018). This movement has not been without its critics; risks of prescribing with lesser medical knowledge have been highlighted, alongside judgement that prescribing is not where the profession's expertise lies (Robiner, Tumlin, & Tompkins, 2013). The issue remains controversial and debated, extending to the United Kingdom (UK) whereby the BPS recently expressed plans to form a task group to consider prescribing rights for psychologists (British Psychological Society, 2018). The debate around psychologists prescribing in the UK is discussed further in 'published articles in the UK' below.

There is little research into involvement with medication distinct from prescribing despite VandenBos and Williams (2000) finding that almost all responding participants in their survey (596 psychologists) were involved with medication in some capacity. The only other relevant study found was again conducted in the US, exploring school psychologists' involvement with students taking psychotropic medication (Carlson, Demaray, & Hunter-Oehmke, 2006). Their

survey found that psychologists were engaging in various roles, such as monitoring behavioural responses to psychotropic medication, monitoring side effects, and developing psychotropic medication treatment goals. However, the purpose of the survey was to compare practice with psychopharmacology training that school psychologists received, and as such, involvement with medication was to be expected.

1.3.3 Published articles in the UK.

Whilst there is a dearth of UK research, commentary articles have been published in clinical psychology magazines and forums considering and debating psychologists and psychotropic medication. Article topics range from the debate on psychologists prescribing (British Psychological Society, 2003) to alternative roles that psychologists may assume (Houghton, 2016). Whilst logistical arguments have been proposed as a benefit for psychologists having prescription privileges (Resnick, 2003), the value of psychology as providing an alternative response to human distress has been proposed as a counter-argument (Johnstone, 2003). An article was published in the *Counselling Psychology Review* in 2001 discussing the notion of prescription privileges for counselling psychologists (King, 2001). The author concluded that a more helpful strategy would perhaps be to obtain a recognised level of awareness of pharmacology to inform consultation with other professionals and clients, a suggestion similarly applicable to clinical psychology. Little appears to have changed for either profession since this time, evidenced by a recent article in *The Clinical Psychology Forum* speculating on whether clinical psychologists' should join the debate around medication, and the suggestion of appropriate roles (Houghton, 2016).

Despite ongoing debate, consensus on psychologists' roles with psychotropic medication has not been reached, and any roles currently being adopted remain undocumented and unknown. In April 2018 the BPS proposed creation of a Prescribing Rights for Psychologists Task and Finish Group within *The Psychologist* magazine (British Psychological Society, 2018). The proposal

indicates that in 2016 the Society was approached by NHS¹¹ England to consider whether there was a need for the extension of prescribing to include psychologists. The item was presented at the General Assembly meeting in 2017, to which it was decided that a proposal will be developed to review the request and instigate consultations with the membership (British Psychological Society, 2018). This proposal remains ongoing and demonstrates the potential changing role of the clinical psychologist specifically in relation to psychotropic medication.

1.3.4 Drivers for involvement.

There are a number of initiatives to reduce the use of psychotropic medication across client groups within the UK, perhaps most notably STOMP (Stopping the overmedication of people with a learning disability, autism or both; Voluntary Organisations Disability Group, 2017). Medication use has been a particular focus for individuals with intellectual disabilities (IDs) following the Winterbourne View hospital scandal (NHS Improving Quality, 2015), but the over-use of medication has also been highlighted in other areas such as individuals with dementia (Thompson Coon et al., 2014) and children and adolescents (Marsh, 2017). National drivers to reduce overall prescribing provide increased rationale for clinical psychologists to become involved with issues and decisions relating to medication, regardless of broader debates. Indeed, it is recognised that for prescribing levels to be reduced in the long term the availability and feasibility of nondrug alternatives need to be addressed and promoted (Thompson Coon et al., 2014; Voluntary Organisations Disability Group, 2017). This reflects a potentially important role for clinical psychologists who are arguably well-placed to promote psychological alternatives to medication. Indeed, leadership skills and use of psychological theory and data to support changes at a wider organisation level are key skills that are considered to make clinical psychology unique in health and social care (Division of Clinical Psychology, 2010).

¹¹ National Health Service

1.4 Roles, Professional Identity and Responsibility

Elements of role theory will be considered in relation to why clinical psychologists may or may not perceive themselves to have a role with their client's psychotropic medication. These aspects will then be considered as to how they may translate into forms of involvement using the triangle of responsibility model (Schlenker, Britt, Pennington, Murphy, & Doherty, 1994).

1.4.1 Role theory.

The origins of the study of 'role' trace back to three schools based on anthropological, sociological, and psychological traditions (Biddle & Thomas, 1966). The schools are credited to the pivotal work of Mead (1934) who explored concepts of the 'self' and 'socialisation', further developing the notion of taking a 'role' in which the 'self' would be influenced by others. There is informal agreement between schools and approaches of several underlying propositions: some behaviours are patterned and are characteristic of persons within contexts, roles are often associated with people who share a common identity, people are aware of roles and they are to some extent governed by their expectations, roles serve a function and are often embedded in larger social systems, and people are socialised into roles (Biddle, 1979). Role theory is extremely broad, and what constitutes definition of a role is difficult (Biddle, 1979). As such, critique has focused on the fact that there is insufficient clarity within the theoretical model and the various definitions proposed potentially invalidate its usefulness (Coulson, 1972). Whilst there may be no single role theory that proves universal in its application, within the overarching theory there are many constructs relating to role that can be singularly considered (Clifford, 1996). Possible constructs will be examined and hypotheses presented in relation to understanding how clinical psychologists construe and behave in their professional roles.

1.4.2 Professional identity and socialisation.

The concept of identity is a useful way of investigating how individuals perform a role or understand their place within a team. A professional identity is a person's image of who they are as a professional, including the attributes, values, and skills that are used to define the professional role (Slay & Smith,

2011). A sense of professional identity is deemed important as it permits acknowledgement of specialised skills and knowledge, emphasising uniqueness from others in ability (Barker Caza & Creary, 2016). Furthermore, professional identity shapes work attitudes and behaviour (Siebert, 2005).

Professional identities develop within the relational context, shaped by the comparison between one's own identity and others. Davies (2003) terms this 'classic professional identity' wherein the way that power is used between professional individuals defines the roles that individuals take. Mastery of knowledge and expertise, and a sense of self apart from others shapes a strong sense of professional identity, however, in doing so can lead to devaluing the 'other'. By process of 'othering', it makes sense to conceive that clinical psychologists differentiate themselves professionally from psychiatrists by the fact that they are not medical prescribers. Indeed, a fundamental answer to the question "what is the difference between professions?" may refer to difference in education and the prescribing of medications (Kingsbury, 1987). It may, therefore, be easy to not identify any role with medication and perceive this as belonging to another's identity. In contrast, expertise that bounds a clinical psychologist to their professional identity is more likely to be psychological formulation; a core skill for practitioner psychologists (Health and Care Professions Council, 2015). This is commonly viewed as an 'alternative' to psychiatric diagnosis (Johnstone, 2018), and largely separate from medical frameworks of mental health.

An additional construct within role theory is professional socialisation, which emphasises how an individual either conforms to a societally expected role, or risks being excluded from the group (Baldwin, 2008). Clinical psychologists are expected to socialise to a professional norm in terms of professional standards set out by the Health and Care Professions Council (HCPC; Health and Care Professions Council, 2015), BPS guidelines (Division of Clinical Psychology, 2010), and also wider expectations as perceived by the public and other healthcare professionals. A sense of professional identity rooted in particular expertise (which does not include medication), 'othering' in terms of associating other professionals with medication, and a lack of current identified normative

roles are all factors which may act as barriers to clinical psychologists adopting roles with their client's medication.

1.4.3 Role ambiguity.

Role ambiguity is characterised by disagreement on what is the accepted norm for a position by virtue of this being ill-defined or unclear (Baldwin, 2008). In relation to professional roles, formal roles are sets of official behaviours that employees perform as part of their job description and can be maintained by organisational policies. In addition, informal roles develop as a result of everyday dynamics of the organisation (Jackson & Schuler, 1985). Role ambiguity is generally operationalised as uncertainty concerning formal roles. Given the question of whether clinical psychologists have a role with their client's use of medication and the uncertainty around this, role ambiguity seems an important construct. As previously discussed, clinical psychologists may not historically identify themselves as holding any form of role based on professional competencies and expectations that medication falls under the role of the psychiatrist. Clinical psychology continues to evolve as a profession, however, adapting to meet changing social demands. For example, the end of the Second World War brought an urgent need for psychotherapy for returning military personnel. By the late 1960s and early 1970s psychologists had become the pre-eminent and dominant providers of psychotherapy, despite initial reluctance of a unanimous embrace (British Psychological Society, 2003). Role ambiguity remains throughout professional role transitions, when parameters are not yet established. Based on increased movement within the profession to advocate a shift away from biological understandings of mental health, it is plausible to consider the role in an evolving state towards gradually embracing roles with medication.

Important guidelines that dictate professional working standards for clinical psychologists in the UK include the Standards of Proficiency for Practitioner Psychologists set by the HCPC (Health and Care Professions Council, 2015) and the Code of Ethics and Conduct set out by the BPS (British Psychological Society, 2009). The Standards of Proficiency state that clinical psychologists must "understand the impact of psychopharmacological and other clinical

interventions on psychological work with service users” (13.17; Health and Care Professions Council, 2015). This suggests that a level of awareness about medication is required, however, it remains broad and does not extend to further roles outside of holding knowledge. As Houghton (2016) outlines in his article questioning the ethical dilemma about clinical psychologists joining the debate on medication, it is important for practitioners to be aware of the limitations of knowledge and not act outside of these boundaries (British Psychological Society, 2009). Lack of specific guidance from professional bodies fails to provide consensus on the accepted norm and role within the position. This leaves individuals to decide the role they wish to perform, potentially resulting in inconsistency across the profession and continued role ambiguity.

1.4.4 Role blurring.

Role blurring refers to the overlap between individual roles within a team, and is thought to be more commonplace in mental health settings compared with physical health, where clearer definitions for healthcare professions exist (Baldwin, 2008). A lack of clarity as to whether involvement with medication forms part of the clinical psychologist’s role may lead to concerns around such involvement being perceived as role blurring. This may particularly be the case when working with a team who do not hold such expectations for the clinical psychologist. Role blurring and reduction of traditional practices has become a significant issue for many practitioners, and whilst diffusion of roles has been considered progressive and flexibly desirable, concerns of losing a sense of professional identity within the multi-disciplinary team (MDT) are also noted (Brown, Crawford, & Darongkamas, 2000). Early work into MDTs saw professional identity as important in terms of navigating team environments (Payne, 1982), identifying the risk that role blurring may have on both individuals and teams. Additionally, Wall (1998) argues that there can be a loss of efficiency when staff share tasks and operate outside their area of expertise.

In regards to medication, there will be some areas that are currently clearly defined as outside of the role, such as prescribing. However, there are many other possible roles that may be within remit but not ‘formally’ defined as such.

This adds to the prior construct of role ambiguity; blurring may occur in attempts to individually make sense of and personally define a role with lack of guidance. Alternatively, fears around role blurring may discourage clinical psychologists from considering any role with medication. Professional roles also change and develop, such as the move towards psychologists adopting responsible clinician roles, a position traditionally held by psychiatry (The Psychological Professions Network Alliance, 2018). In its early stages this might be perceived as role blurring, however, it demonstrates how professional identities and roles are open to change. In this context of the changing profession it is conceivable to foresee future development in how clinical psychologists view their role with medication, with potential shifts in professional identity to account for such change.

1.4.5 The triangle of responsibility.

The triangle of responsibility (Figure 3) is a model that provides a coherent framework for understanding how an individual might act in a given situation based on personal responsibility versus identity, perceived control, and clarity of actions (Schlenker et al., 1994). The above constructs of role theory can be synthesised using the model to hypothesise how this translates into action, or no action as the case may be. According to the model, responsibility (and therefore inclination to act) is a direct function of the combined strength of the three linkages, as perceived by the individual who is making the judgement. In this view, responsibility is the adhesive that connects an individual with an event and a set of prescriptions for conduct. Studies have supported the model, showing that attributions of responsibility are a direct function of the combined strength of the three linkages, and when judging responsibility information relevant to the linkages is sought (Schlenker et al., 1994). The model has useful applications in considering the role of clinical psychologists and psychotropic medication. In regards to the model, 'prescription' refers to involvement with psychotropic medication, and is not to be confused with pharmacological prescribing. Each link will now be considered in regards to the clinical psychologist's role.

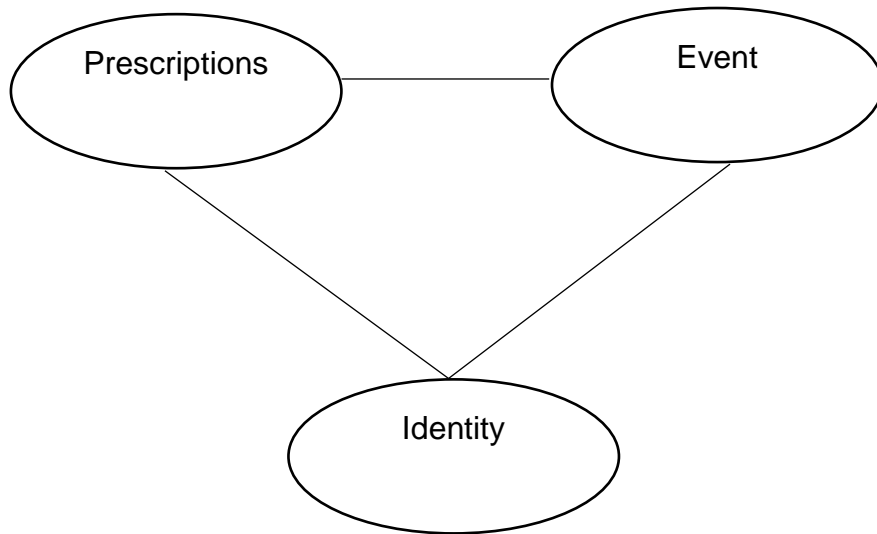


Figure 3. Triangle of responsibility

1.4.5.1 Identity-prescription link.

The identity-prescription link refers to the extent to which the prescriptions are perceived as applicable to the individual by virtue of their characteristics and roles. As discussed, there is presently a great deal of role ambiguity for clinical psychologists given professional drivers to move away from the medical model, alongside a lack of clear guidance in regards to roles. This creates uncertainty and debate about the relevancy of the prescription, both of which are factors considered to weaken this link. The link is severed if the prescriptions are not relevant to the identity of the individual. This introduces subjectivity as to whether an individual considers medication relevant to one's role, impacting the responsibility a person may feel to become involved. Identity crises are said to occur when people lack a clear sense of role and are uncertain about what prescriptions they should follow. Uncertainty surrounding a role with medication may leave psychologists questioning their professional identity. Identities change over time, and as identity shifts, prescriptions that are regarded as applicable will be adapted (Schlenker et al., 1994). Consequently, this link might be strengthened if clinical psychologists perceive medication as part of their role, increasing feeling of responsibility and likelihood of acting.

1.4.5.2 Identity-event link.

The identity-event link is the degree to which an individual appears connected to the event. This may simply be due to their group membership, or the extent to which they have personal control over the situation. As perceived personal control decreases, so does responsibility for taking action. This link is anticipated to be weak for many psychologists, who might consider themselves to hold a lack of personal control over a client's psychotropic medication due to not holding prescription rights. This is likely to reduce a sense of responsibility to become involved with medication, with the expectation that any role falls under the psychiatrist's remit.

1.4.5.3 Prescription-event link.

The prescription-event link refers to the extent to which clear rules and expectations governing the prescription exist. The link is considered to be weaker when goals and rules are ambiguous, subject to alternative interpretation, or conflicting. Role ambiguity with medication creates a weak linkage, whereby there are no clear rules to guide involvement. A lack of clear expectations reduces responsibility for involvement due to no template for which to act in. The authors suggest that individuals may make excuses for not acting in such situations by highlighting a lack of instructions, in an attempt to further weaken the link.

1.4.5.4 Triangle of responsibility summary.

The model brings together prior role theory concepts of professional identity, role ambiguity, and role blurring to consider how such concepts might reflect clinical psychologists' judgement around any role with medication. The model accounts for understanding how a role may be considered out of remit, however, at this stage cannot explain how and why clinical psychologists might undertake involvement. It is hoped that the current research can provide further insights as to how clinical psychologist judges a role with medication.

1.5 Rationale for the Current Study

International research suggests that psychologists are likely to encounter a variety of opportunities to adopt some form of role with clients' psychotropic

medication, and are extensively, albeit indirectly, involved in the process of prescribing and managing clients' psychotropic medications (VandenBos & Williams, 2000). There is a dearth of research exploring psychologists and their role with psychotropic medication in the UK. However, given the extensive use of psychotropic medication (Health and Social Care Information Centre, 2017) it seems likely that similar opportunities and practice may occur. This has important implications for practice, given current unawareness about how psychologists are navigating such issues in light of no structured guidelines advocating practice. This gap in the literature identifies a need for in-depth research that explores not only whether psychologists are choosing to involve themselves with psychotropic medication, but how and when this is happening, and the rationales behind these choices.

In addition, the collective clinical psychology profession is taking more of a stance against a dominantly biological understanding of mental health (Division of Clinical Psychology, 2013). This sets precedence for exploring the relationship between clinical psychology and psychotropic medication in terms of questioning what involvement clinical psychologists are currently having, and potentially what role they could have.

1.6 Researching Clinical Psychologists

It is important to research the experiences of clinical psychologists due to the reflective nature of the profession. Using reflection within clinical practice has been noted to help clinical psychologists understand their professional role as clinicians, and maintain professional and ethical standards (Fisher, Chew, & Leow, 2015). Furthermore, the BPS considers reflection as fundamental in continuing good practice in relation to clients, service delivery, and for professional and personal development (British Psychological Society, 2008).

There is also a qualitative research base exploring clinical psychologists and decision making behind aspects in their role (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013; Tickle, Brown, & Hayward, 2014), which is helpful in understanding challenges faced within clinical practice. A discursive analysis exploring how clinical psychologists conceptualise 'mental health' suggested an

ethical need for clinicians to be honest about their assumptions of what 'mental health' means in order to reduce the risk of service users complying with a process they do not fully understand (Lofgren, Hewitt, & das Nair, 2015). Putting these suggestions into practice creates opportunities for clinical psychologists to share how the use of psychotropic medication fits with their conceptualisation of mental health. Examining clinical psychologists' involvement with psychotropic medication in a qualitative format can promote reflective thinking in order for clinical psychologists to consider (and potentially reconsider) their position in regards psychotropic medication.

2. Extended Method

This section expands on the method section of the journal paper by providing the rationale behind methodological decisions, and increased detail about the researcher's epistemological position. Qualitative approaches considered for data analysis will be briefly summarised before outlining the rationale for using thematic analysis (Braun & Clarke, 2006). Lastly, the study design, online survey development, interview schedule development, sampling, inclusion criteria, ethical considerations, data collection and quality assurance procedures are discussed.

2.1 Method Overview

Due to a paucity of literature on the research topic, a dual approach to research aims was adopted using a mixed method sequential explanatory design. The qualitative component aimed to expand on the quantitative, with findings from both phases synthesised. The research process aimed to gather data investigating methods and frequency of clinical psychologists' involvement with client's psychotropic medication on a broad level, before seeking more in-depth data about the rationales behind these decisions. A mixed methods approach was deemed appropriate for these dual aims.

2.2 Epistemology

Qualitative and quantitative research methods are underpinned by different philosophical assumptions. The use of mixed method research approaches has given rise to debates over the rationale for combining what have previously been considered incompatible paradigms (Hall, 2013). These include ontology which is concerned with what constitutes reality and epistemology, how reality can be created, acquired, and communicated (Scotland, 2012). All research has a philosophical foundation and researchers should be aware of the assumptions they make about knowledge, as this shapes the research process and method of inquiry (Creswell & Plano-Clark, 2011).

Quantitative approaches are rooted in positivism which holds assumptions that reality is objective and absolute knowledge can be sought (Scotland, 2012). As such, meaning exists independently of the conscience of the researcher; it is

their aim to obtain this meaning as it exists (Pring, 2000). Positivist methodology attempts to identify causes and effects with a view to provide outcomes that can be generalised to a wider population than studied (Creswell, 2009). This study rejects the assumptions of positivism as the researcher believes that subjective experience plays an important role in what can be discovered about reality. Qualitative approaches stem from the interpretivist paradigm, rejecting the idea that there is one correct version of reality or knowledge (Braun & Clarke, 2013; Mcevoy & Richards, 2006). There are multiple realities and 'knowledges', and the aim is to understand how people make sense of the world and how they experience events (Braun & Clarke, 2013; Willig, 2013). Prediction of outcomes and generalisability are not meaningful goals within qualitative research, rather the aim is to understand and interpret phenomena within its context (Braun & Clarke, 2013). Rich data is sought, often through data collection methods such as interviews or focus groups, usually with a smaller sample size than quantitative methods (Braun & Clarke, 2013).

A challenge recognised in mixed methods research is the capability of combining philosophical stances. In order to overcome paradigm incompatibility, pragmatism offers an approach which focuses on the question and consequences of research, rather than advocating a rigid position on the measurement of human experience (Bryman, 2007). As such, epistemological and ontological issues are diminished in favour of choosing methods best suited to answering the research question in order to solve real-life problems (Feilzer, 2010; Hall, 2013). Whilst this may offer a practical approach to research, failing to provide philosophical justification for methods causes difficulties during data interpretation as to claims that can be made about the data (Hall, 2013).

An alternative approach to the paradigm dilemma is for the researcher to draw from multiple epistemological approaches with assumptions shifting according to the method in current use (Creswell & Plano-Clark, 2011). This may be advantageous in keeping the methods separate in order to draw upon the strengths of each (Morse, 2003). However, conjoining incompatible paradigms creates challenges in clearly reporting how this has been done, impacting the

reliability of claims due to a lack of transparency in research decisions (Hall, 2013).

The single epistemological position of critical realism can be adopted to overcome difficulties in integrating paradigms based on different assumptions and still encompass both quantitative and qualitative approaches (Hall, 2013).

2.2.1 Critical realism.

Critical realism offers an alternative philosophical perspective to the established paradigms of positivism and interpretivism (Houston, 2001; McEvoy & Richards, 2003), and has been advocated as an appropriate paradigm for combining quantitative and qualitative methods (Sayer, 2000). Its suitability is achieved by integrating positivism and interpretivism by making assumptions that by nature of studying reality through human participants, reality is unlikely to be represented in a pure form (Harper & Thompson, 2012). The position assumes that a true reality independent of observers exists, however, it is impossible to fully apprehend this reality because perceptions are framed by investigative interests and theoretical resources. Empirical feedback about accessible aspects of the world can be collected, but this knowledge is mediated by discourses available (Sayer, 2004) and influenced by context (including participant-researcher interactions), prior beliefs, and socio-cultural factors (Deforge & Shaw, 2012).

A critical realist researcher seeks explanatory understanding by moving from the level of observations and lived experience in order to hypothesise about underlying mechanisms accounting for the phenomena, known as 'retroduction' (Mingers, 2003). As the mechanisms themselves are dependent upon the variable conditions in which they operate, generalisability is not the researcher's aim (Lawson, 2003). It is neither the aim to identify the lived experiences of individuals. Rather, the critical realist's aim is to develop deeper levels of explanation and understanding regarding the phenomenon under study (McEvoy & Richards, 2006).

Critical realism was deemed to be an appropriate paradigm given the aims of the study: to explore frequency and of experiences of a phenomenon. The

approach permits quantitative and qualitative data to be combined to develop a deeper understanding. Philosophical assumptions inform theoretical stance, which in turn informs methodology (Creswell & Plano-Clark, 2011).

Methodological decisions will now be explained.

2.3 Mixed Methods Research

Mixed methods research is recognised as the third major research paradigm, aiming to consider the viewpoints and perspectives of both quantitative and qualitative approaches (Johnson, Onwuegbuzie, & Turner, 2007). Quantitative and qualitative methods each make valid contributions to research, and using both methods together can reveal other areas of the topic at study (Harper & Thompson, 2012). Quantitative methods have the strength of developing reliable descriptions with the ability to provide comparisons, and can help to identify patterns that may otherwise be masked. Qualitative methods can help identify more complex concepts and relationships that may not be captured by predetermined response categories (Creswell & Plano-Clark, 2011).

Despite the paradigm-compatibility debate it is argued that a mixed approach can be valid when used for complementary purposes, as combining approaches allows for a greater understanding of complex issues than either approach used alone (Sale, Lohfeld, & Brazil, 2002). Another cited advantage is triangulation, used to enhance the credibility of findings (Mertens & Hesse-Biber, 2012). As each method studies different phenomena the distinction of each is considered crucial (Sale et al., 2002). The phenomenon of 'involvement' may appear the same across both methods, but the distinction lies between a 'measure' and 'lived experience'. This promotes transparency and links the phenomenon to its corresponding paradigm and method.

Mixed methods research has been subject to various criticisms which will now be addressed. It has been argued that qualitative aspects of the design can be undermined as precedence is can be given to quantitative components (Morse, 2003). Johnson et al., (2007) define different types of mixed methods research, offering a continuum whereby research may be mixed at its "purest" form in the centre or may branch out to be dominantly qualitative or quantitative.

Positioning the research on this continuum is helpful in determining which, if any, method takes precedence within the research and minimises undermining one aspect. Within the current study, the qualitative component encompasses a larger volume of the results, however, both aspects are awarded equal weighting. The qualitative component was deemed important as the complexities behind participants' involvement may not have been fully understood in adopting a solely quantitative study. Also, the quantitative component is important as the qualitative method on its own would have been limited in gaining a full understanding in the frequency and types of involvement clinical psychologists are typically engaging in.

Finally, difficulties with integration are noted to be a challenge within mixed methods research. This is considered especially important during data analysis, otherwise resulting in misleading conclusions and the risk of representing multiple studies (Yin, 2006). Challenges were overcome by utilising research supervision to gain alternative perspectives during the process of analysis, and applying quality insurance measures (further discussed in section 2.7). The research time line has been suggested to impact the extent to which both data sets feel can feel separate and out of sync with one another, and may inhibit integration as one set is generated faster than the other (Bryman, 2007). This was managed by continuing to refer to the quantitative data during supervision of analysing the qualitative in order to compare and contrast findings, and gain initial ideas about synthesisation.

When combining methods it is important to consider and address paradigm differences (Harper & Thompson, 2012). Firstly, an online survey was used which aligns with positivism; assumptions about the data being that it represents a true reality independent from participant effects. The survey also included a free-text question response, however, opening up individual interpretation and shifting away from positivism. From a critical realist position, it is assumed that the reality measured by the survey is imperfect as there will be subjectivity in how participants interpret the questions and choose to respond. Secondly, semi-structured interviews were analysed using thematic analysis, which is not tied to an epistemological position and so can be approached from

a critical realist perspective (Braun & Clarke, 2006). Focus is on individual experiences but unlike constructivism, which may caution against generalisation due to assuming multiple realities exist, it was assumed that individual experiences may share commonalities. As such, themes were derived across the data highlighting similarities and differences.

2.4 Study Design

In this section further information on decisions made in regards to the study design are discussed.

2.4.1 Online survey.

An online survey was used with the aim of collecting data from a large sample in order to maximise representativeness of the profession (Appendix B). Online surveys are considered cost-effective, efficient, and lessen the demand placed on participants who can opt-in and complete the survey in their own time (Murdoch et al., 2014). There is evidence to suggest that online surveys can produce valid and reliable data, and have the advantage of extending the geographical sampling area, increasing the chance of reaching a representative sample (Hewson, 2014).

2.4.2 Semi-structured interviews.

Semi-structured interviews were used to expand on the data collected from the online survey in order to gain further detail and insight into participant experiences. They are an appropriate method of data collection when using thematic analysis (Braun & Clarke, 2006), and were considered more appropriate than focus groups which would have caused organisational challenges due to the geographical spread of participants. Focus groups also may not have allowed for such in-depth exploration of individual experiences.

Interviews are the most common method of qualitative data collection (Braun & Clarke, 2013) and are typically considered the 'gold standard' in terms of validity and rigour (McCoyd & Kerson, 2006; Novick, 2008). The method is not without limitations, however, as conducting individual interviews is time consuming for both the researcher and participants. Participants in the current study were

working professionals who would not necessarily derive gain through their participation. Nevertheless, interviews are advantageous in allowing collection of rich and detailed data about individual experiences, with the benefit of flexibility in terms of follow-up and unplanned questions based on participant responses (Braun & Clarke, 2013). As such, the researcher has the ability to guide the interview, increasing likelihood of obtaining useful data in relation to the research aims (Braun & Clarke, 2013).

The advantage of collecting a geographically diverse sample during the first stage of data collection resulted in practical challenges in conducting face-to-face interviews. Selection based on location would have limited the integrity of the data. Much social science research suggests that face-to-face interviewing is the most productive method of gathering narrative data, and has been assumed superior in ensuring quality of data (Holt, 2010). However, there is little evidence of data loss or a compromise on quality of findings when interview data is collected by telephone (Novick, 2008). Additional benefits to telephone interviews are also noted, such as practicality, decreased cost and travel, and increased articulation due to a lack of non-verbal communication (Holt, 2010; Novick, 2008). These advantages can also be extended to the use of video-conferencing software such as Skype, with the additional benefit of enabling the 'visual' in the interview setting (Hanna, 2012).

In order to practically collect a range of responses based on the sampling method without impacting on the research budget face-to-face, telephone, and Skype interviews were considered feasible methods to collect data. Participants were offered a choice in how the interview was conducted; all were offered Skype and telephone, those within a 100-mile radius of the researcher were also offered face-to-face. Of the eleven interviews conducted, two were conducted face-to-face, three were via Skype and six were over the telephone. Interviews lasted between 40-60 minutes.

2.4.3 Inclusion criteria.

The inclusion criteria are detailed in the journal paper, although it is necessary to expand on why only clinical psychologists were recruited. The HCPC

Standards of Proficiency for Practitioner Psychologists reference awareness of psychotropic medication for only clinical and counselling psychologists, stating they should “understand the impact of psychopharmacological and other clinical interventions on psychological work with service users” (13.17; Health and Care Professions Council, 2015). It was felt important, however, to match participants as closely as possible in terms of profession in order to explore within-profession variety, given the paucity of literature in the area and unnecessary of comparing different practitioner psychologists.

In order to match participants as closely as possible in terms of professional training, the decision was made not to open the research to other practitioner psychologists. This is because alternative practitioners may be less likely to work with individuals who are prescribed psychotropic medication (such as sports psychologists or occupational psychologists), and there would be greater variance in professional training. There are undisputedly differences within clinical psychology training programmes, however, it was felt that this maintained participant similarity to the best of researcher ability.

2.4.4 Sample size

2.4.4.1 Online survey.

A total of 147 participants participated in the online survey and there was no target number of participants required. The survey was live between the dates of 14.01.17 and 30.04.17. As this was an opportunistic opt-in study no data was collected on people actively choosing not to participate. Recruitment was achieved through a broad advertising strategy, as such it is not possible to state total numbers ‘approached’ to participate.

It is important to consider how the sample relates to the overall number of clinical psychologists in the UK. There are approximately 12, 705 clinical psychologists registered with the HCPC (figured attained 02/01/2018) (Health and Care Professions Council, 2018). The sample of respondents are, therefore, less than 2% of the total number of clinical psychologists working in the UK which is important to bear in mind with regards to the generalisability of results. Participants worked in a variety of services, it is not possible to

ascertain whether the percentage of participants working in different areas is generalisable to the profession as a whole in the UK as such figures were not possible to attain.

It is also noteworthy that just under half (49%) of participants had been qualified for less than five years. This may be reflective of the sampling strategy adopted; participants were primarily recruited using social media pages which may be used more frequently by newly qualified (and potentially younger) clinical psychologists.

2.4.4.2 Semi-structured interviews.

A total of fifteen participants were approached and invited to take part in interviews; eleven interviews were ultimately conducted. Within qualitative research the total number of participants recruited is often determined when data saturation is considered to be reached, a concept derived from grounded theory analysis (Bowen, 2008). There is no universal method in reaching data saturation given the diversity in research designs. Typically, saturation is said to occur when additional data fails to generate new information and the study could be replicated (Guest, Bunce, & Johnson, 2006; Morse, 1995). Whilst this appears a logical approach to sampling, in reality the concept of reaching saturation remains ambiguous as there are no pragmatic guidelines in existence (Fusch & Ness, 2015). Perhaps as a consequence, the concept of saturation is often mentioned in qualitative research reports, however, little explanation offered as to what this means within the context of the study (Bowen, 2008). Furthermore, it cannot be assumed that data saturation has been reached because available resources have been exhausted. It may be conducive then to think about sampling cut-offs in terms of when data *sufficiency* has been reached. That is, asking the question 'Is the data I have collected sufficient to answer my research question?'. This was considered by use of reflective diary and research supervision. A reflective diary quote after interview number 8 reads:

"I feel the interviews are going well so far, although I am getting the sense of many participants reporting the same kinds of things".

Within research supervision it was discussed that whilst there was a variety in narrative and experience, there was a general sense of coherence in participant stories. At this point further interviews were still scheduled and were completed with some confidence that sufficiency had been reached. As part of the analysis process, transcripts were read multiple times for familiarity. By becoming immersed in the data, researcher confidence further increased that data quantity was adequate in order to answer the research question.

Furthermore, the final sample size falls within the 'moderate' criteria as advised by Braun and Clarke (2013). It is suggested that when conducting interviews, a small sample size would include six to ten participants, with moderate samples ranging from 10-20 participants.

2.4.5 Recruitment.

2.4.5.1 Online survey.

In order to maximise recruitment methods of advertisement and direct targeting were used in conjunction. An advertisement (Appendix C) was posted on social media and professional web pages that were known to be used by clinical psychologists. An advertisement (Appendix D) was also published in the DCP Forum as a response to a previous article about clinical psychologists joining the debate around medication (Houghton, 2016). The advert provided an email address for potential respondents to contact if they were interested in taking part in the study. The advertisement was also emailed to private healthcare companies who employ clinical psychologists, and around administration staff working on Doctorate in Clinical Psychology training courses to circulate. Further details of the recruitment strategy can be found in Table 9.

Table 9.

<i>Recruitment networks</i>	
Recruitment Network	Additional Details
Email advertisement	
Cygnnet Healthcare	
St Andrews Healthcare	
DClinPsy Courses	
Advertised online	
ClinPsy Forum	Posted once
Facebook Clinical Psychology page	Posted three times
Facebook Assistant Psychologist page	Posted once
Twitter	Tweeted 9 times (snowballed)
Linkedin	Advert posted once
BPS Facebook page	Advert posted once
Publication of advertisement	
Division of Clinical Psychology Forum	Email address provided as contact

2.4.5.2 Sampling.

2.4.5.2.1 Semi-structured interviews.

Purposeful sampling is a widely used technique in qualitative research for the identification of information-rich cases (Patton, 2002). This involves a process of identifying individuals who are particularly knowledgeable or experienced with the phenomenon under interest (Creswell & Plano-Clark, 2011). Intensity sampling was used to sample prior participants who completed the online survey and provided consent to take part in interviews (Palinkas et al., 2015). Falling under the umbrella of purposeful sampling, intensity sampling requires the researcher to explore variation within the phenomenon under study before sampling relevant intense examples. This method assumes that much can be learned from the data by looking at the ends of the distribution range. This approach is not dissimilar to extreme sampling, however, is used with decreased emphasis on 'extreme' cases in order to identify and expand the range of variation or differences (Palinkas et al., 2015).

Intensity sampling was adopted due to interest in participants whose involvement with psychotropic medication was reported to be at either end of the continuum (i.e. no/little involvement and great involvement). This was in attempt to represent a selection of views and experiences, and minimise skewing data by only interviewing individuals with similar opinions. Consequently, respondents who fell into the 'middle' range were not sampled for interview. Selecting individuals who meet specific criterion in relation to their experience may fail to capture the experiences of other roles in the process (Palinkas et al., 2015). Given the small sample size selected for interview compared with the overall sample, this does risk excluding a proportion of clinical psychologists who fall in the 'middle' and may arguably be more representative of the overall profession. However, given lack of previous research the phenomenon is currently poorly understood, and so intensity sampling was deemed appropriate on the basis of drawing out opposing experiences and opinions in order to begin to define the phenomenon of interest. This approach maximises ability to compare, contrast, and identify similarities and differences whilst assuming that the middle falls between these points. Additionally, a systematic sampling strategy was required for practicality and selecting a sample of contrasting participants was deemed pragmatic. In order to maximise representation and include participants whose responses fell into the middle a larger number of interviews would be warranted, but there is little evidence to suggest that additional data would add value to overall findings. Finally, despite use of intensity sampling there did not appear to be definitive differences in views and opinions between participants rated as having 'high' or 'low' levels of involvement. This suggests that attempts to include participants within the middle range may not necessarily have added further value to findings.

Use of a single strategy for purposeful sampling for qualitative components of a mixed methods study has been suggested to adhere to the same general principles that govern all forms of sampling (Palinkas et al., 2015). Seven such principles have been identified (Kemper, Stringfield, & Teddlie, 2003). These principles and how they were met are outlined in Table 10.

Table 10.

Strategy for purposeful sampling

Principles	How principles were met
The sampling strategy should stem logically from the conceptual framework as well as the research questions being addressed by the study	The research question asked about current roles and forms of involvement which invites diversity in responses
The sample should be able to generate a thorough database on the type of phenomenon under study	Diversity in service worked in and frequency of involvement aimed to maximise thoroughness
The sample should at least allow the possibility of drawing clear inferences and credible explanations from the data	Intensity sampling aimed to maximise potential for interviewing participants with experience and knowledge on the phenomenon
The sampling strategy must be ethical	Only participants who had provided consent were included
The sampling plan should be feasible	A systematic plan was derived which was deemed feasible by researcher and supervisor
The sampling plan should allow the researcher to transfer/generalize the conclusions of the study to other settings or populations	Inclusivity across services were included
The sampling scheme should be as efficient as practical	The systematic plan allowed for efficiency and practicality

(Kemper et al., 2003)

Recruiting participants with recent high and low levels of involvement presented the challenge of quantifying involvement. This study adopted the definition of involvement as gaining knowledge, considering how to put this knowledge into action, or a form of activity within practice that may influence a change or maintain a client's medication regime. The survey offered a variety of involvement options, but determining whether some items carry more weight (i.e. indicate 'more' involvement') introduces subjectivity, and as such, all items were considered equal in terms of quantification. Involvement was measured in terms of frequency of items selected. Respondents who ticked 'none' or fewer items were considered least involved, and respondents who ticked the highest numbers of items were considered most involved. It was also felt important to reflect the variety of services participants worked in, therefore, the selection process also aimed to involve fair representation of service types.

2.4.5.1.2 Sampling strategy.

Criteria were developed and independently used by two researchers against responses of all participants who consented to interview. The criteria are outlined below: -

1. Responses are separated by service (adult, ID, CAMHS, older adult, physical health, other). In cases where more than one service has been selected (e.g. a respondent working in both adult and CAMHS) the service with the least overall number of participants is chosen, or they are placed according to the service they referred to in their qualitative answer (e.g. making reference to CAMHS).
2. Frequencies are totalled for each respondent for the question "What kinds of involvement have you had with psychotropic medication in the last six months?". The highest and lowest frequencies for each service are then selected.
3. In instances when there are multiple responses per service with similar levels of involvement, qualitative responses are inspected to see if anything is written relating to the role of a psychologist with psychotropic medication, or whether a strong view is expressed one way or the other; these responses are prioritised.
4. Equal numbers of high and low involvement across services are picked.

Following this, twelve of the same respondents were selected by both researchers. To select the remaining three, both researchers discussed the potential respondents and agreed based on ensuring representation of services. An invitation to interview was emailed to the 15 selected respondents. Remaining participants formed a 'back up' list should any of the participants have declined to take part.

2.4.6 Data Collection.

2.4.6.1 Demographic information.

Demographic information was collected to contextualise the sample and aid researcher interpretation. The information in Table 11 was collected as part of the online survey.

Table 11.

<i>Demographic information collection</i>	
Demographic information	Purpose
Gender	To see whether the percentage of participants reflect the profession in general
Number of years qualified	To contextualise the sample
Working in inpatient or community	To contextualise the sample
Type of service currently working in	To see whether service type affected forms or frequency of involvement
Dominant psychological approach used	To contextualise the sample

When analysing interview data this demographic information was also considered relevant in understanding the person behind the analysis, and how these factors might affect their responses.

2.4.6.2 Instruments.

2.4.6.2.1 Online survey.

The survey was created using Qualtrics, an online survey tool. Construction of the survey was based on the previous study by VandenBos and Williams (2000), and discussion within supervision about research aims and expected outcomes. In order to answer whether clinical psychologists have a role with psychotropic medication it was felt that the survey should elicit data in relation to: 1) clinical psychologist's current experiences of having a role with psychotropic medication, 2) clinical psychologist's opinions on whether there should be a role (regardless of experience with involvement), and 3) opinions/views on psychotropic medication in general, as this was considered likely to shape involvement.

2.4.6.2.2 Development of online survey.

2.4.6.2.2.1 Decision-making in regards to involvement options.

A range of potential options were required in order to gather quantitative data measuring the frequency of involvement. These options were influenced by the VandenBos and Williams (2000) study. The authors offered a variety of options and invited respondents to select which they regularly engage in (Appendix E). The authors do not explicitly state the decision-making process behind their selection of options. E-mail contact revealed that the survey was based on their knowledge and understanding of psychologists' clinical practice in the US. Research supervision was used to discuss creation of the online survey. Options from the VandenBos and Williams (2000) survey were included with suitable adaptations to reflect UK practice. Further adaptations were made to include an increased range of response options to prevent restriction of narrow ideas, and incorporate wider ideas of involvement. Researcher professional positions of trainee and qualified clinical psychologists enabled discussion and extended options to be added based on own experiences and knowledge of practice. A free text option was also included for respondents to offer alternative

forms of involvement not mentioned to minimise exclusion and capture all potential experiences.

2.4.6.2.2 Decision-making in regards to survey questions.

Initial questions collected information relating to years qualified as a clinical psychologist, type of service worked in, and dominant psychological approach used in practice. It was hypothesised that such participant characteristics may potentially have some effect on decisions regarding involvement with psychotropic medication and were helpful in contextualising the data. The questions included in the study that invited respondents to select options of involvement were: -

- What kinds of involvement have you had with psychotropic medication in the last six months? (Please tick all that apply)
- Regardless of your current involvement, which of these options would you do given the opportunity? (Please tick all that apply)
- Are there any options that you feel are inappropriate for Clinical Psychologists to be engaging in? (Please tick all that apply)
- Which three forms of involvement do you consider the most important for Clinical Psychologists to be engaging in? (Please select three items, unless choosing option one)

The primary aim of the research was to explore what involvement clinical psychologists are currently having, so this question was restricted to involvement in the last six months. This was also to increase the chances of accurate memory recall. In the potential instance that overall involvement was found to be very low, the three further questions were added so that respondents could report forms of involvement they would choose to adopt, and also any forms they felt to be inappropriate or particularly important. This was based on an assumption that some clinical psychologists may not currently have active roles with medication but would opt to do so should their role allow.

Additionally, participants were asked whether they had completed any training relating to psychotropic medication within the following questions: -

- 'Have you completed any significant training relating to psychotropic medication? If you answer 'Yes' please select approximately how many days training.'
- Approximately how long has it been since you completed any significant training relating to psychotropic medication?
- Which professional group did the trainer(s) belong to?

This was incorporated to explore whether clinical psychologists were largely receiving or seeking training on psychotropic medication, and who the training was frequently being delivered by.

2.4.6.2.3 Development of semi-structured interview schedule.

Extant literature on the research topic is limited; as such, the interview schedule (Appendix F) was developed through researcher discussion, piloting with trainee clinical psychologist colleagues, and refinement following online survey results.

The interview schedule was used sequentially for the most part, however, was used in a flexible manner to allow for follow-up questions. Questions initially elicited participant opinions and views on psychotropic medication before asking about specific examples of when they had been involved with a client's psychotropic medication. Questions were designed to allow for participants to report their thoughts on involvement even if they had little opportunity to do so themselves in their work.

Interview data were collected by the researcher, and transcribed by external transcription services following signing of a confidentiality agreement (Appendix G).

2.5 Ethical Considerations

This study was reviewed and approved by the University of Lincoln's Research Ethics Committee (Appendix H). Ethical guidance stipulated by the BPS (British Psychological Society, 2009) was adhered to throughout the research process.

2.5.1 Informed consent.

Two participant information sheets were developed for each phase of the research (Appendix I). Both informed potential participants of the purpose and nature of the study. Both information sheets included researcher and supervisor email addresses to provide opportunity to ask questions, and stated that participation was voluntary. Consent was given by selecting the appropriate boxes on the questionnaire, or completing an electronic or paper consent form prior to interview (Appendix J).

2.5.2 Right to withdraw.

Participants were provided with a debrief following their participation (Appendix K) informing them that they were free to withdraw at any time without requiring to give a reason, and that there was a period of two weeks during which data could be withdrawn. Participants were informed that in the event of withdrawal, data may still be used anonymously in the project analysis. No participants opted to withdraw from the study; in the event of this occurring attempts would have been made to seek consent for data to be used in final analysis.

2.5.3 Risks to participants.

There were no serious risks posed to participants resulting from their involvement in this study. Time demands placed on participants were managed by offering choice as to time of day and method of conducting the interview was most convenient for the participant.

2.5.4 Confidentiality and anonymity.

Participant information sheets outlined the limits of confidentiality. Prior to interviews participants were reminded about confidentiality in relation to talking about their own experiences with clients. All participants were allocated a participant number which was saved with their email address in a password protected document on an encrypted memory stick, and pseudonyms were used in the final write up. Participants consented to quotes being used with awareness that these would be anonymised in report and publication.

2.5.5 Storage of information.

Online survey data was held within the online survey tool Qualtrics. All other data was securely held in a locked filing cabinet at The University of Lincoln. Only the researcher and research supervisors had access to the interview data. All participant identifiable data was stored separately to interview transcripts. This information will remain securely stored at the University of Lincoln for seven years in accordance with University protocol, after which time it will be securely destroyed.

2.6 Analysis

2.6.1 Survey data.

Survey data were largely subject to descriptive analysis in regards to the frequencies of options selected. Logistic regression analyses were also used to explore any relationships between type of service worked in and options for involvement within the last six months selected. Logistic regression is considered well-suited for describing and testing hypotheses about relationships between a categorical outcome variable and one or more categorical or continuous predictor variables (Peng, Lee, & Ingersoll, 2002).

The qualitative survey data was coded and clustered into themes using a thematic analysis approach (Braun & Clarke, 2006). Following creation of themes, this data was not subject to further analysis but was used to develop a deductive framework along with aspects from the quantitative data analysis (Appendix L). This was achieved by incorporating the options that had been most frequently selected, along with the themes derived from coding.

2.6.2 Interview data.

Thematic analysis was used to analyse data within interview transcripts. This approach acknowledges how individuals make sense of their experiences within a broader social context, whilst retaining focus on the limits of reality (Braun & Clarke, 2006). Creation of the deductive framework allowed for a dual deductive-inductive approach to be used for the interview data analysis. Transcripts were initially coded inductively, then scanned using the framework.

Other qualitative approaches considered are outlined below, followed by a rationale of the approach taken.

2.6.2 Qualitative Methods

2.6.2.1 Interpretative Phenomenological Analysis (IPA).

IPA aims to examine how people make sense of unique experiences and is informed by hermeneutics; the theory of interpretation (Smith, Flowers, & Larkin, 2009). The researcher plays a reflexive role in that they are interpreting the participants' interpretation of their experienced phenomenon (Willig, 2013). IPA aims to capture the experiences and meanings associated with a phenomenon, rather than to identify opinions about it. It was not considered the most appropriate method of analysis as the current study was interested in participants' opinions and ideas behind their decision making in order to understand the phenomenon under study.

2.6.2.2 Grounded Theory.

Grounded theory is an inductive approach that allows the researcher to develop new theory based on what is held in the data, rather than rely on pre-existing analytical constructs or theories (Tweed & Charmaz, 2012). Whilst grounded theory is useful when there is a limited amount of research in a particular area (Cho & Lee, 2014), it was not considered an appropriate method of data analysis due to the mixed method design of the research. It was intended for data from the online survey to influence the analysis of the interview data and a deductive framework was created to aid this process to facilitate integration of both phases.

2.6.2.3 Foucauldian Discourse Analysis (FDA).

Discourse analysis is concerned with how language is used in order to construct phenomena; FDA takes this beyond the immediate settings within which language is used and considers the effects of discourses within social context. Discourses can facilitate, limit, enable, and constrain what can be said, by whom, where and when, creating subject positions adopted by individuals which have implications for their subjectivity and experience (Willig, 2013). FDA could have permitted examination of how participants construed power in relation to

their role with psychotropic medication and their wider team. Whilst interesting, this would have provided a narrow focus, and not fully address the question of whether clinical psychologists have a role, and specifically what this role looks like.

2.6.2.4 *Thematic analysis.*

Thematic analysis is a method for identifying, analysing, and interpreting patterns of meaning across qualitative data (Braun & Clarke, 2006). As a form of qualitative analysis, thematic analysis is unique in that it can be applied across a range of theoretical frameworks and acts as a tool for which to approach data. The researcher adopts a systematic approach working through a series of steps in order to generate initial codes and develop themes representing patterns of meaning. Thematic analysis was adopted for its flexible approach and its usability as a technique to identify patterns across and within data in relation to individuals experience, views, and perspectives (Braun & Clarke, 2013).

Whilst considered a strength, thematic analysis has also been criticised for its flexible nature with claims that it is undefined and lacks transparency (Antaki, Billig, & Potter, 2003). The use of thematic analysis as a tool does not in itself provide a clear theoretical basis for research (Willig, 2013). In order to overcome such limitations, the researcher is required to make a number of decisions and be explicit about these decisions. This includes epistemological position, how the data is approached and codes generated, and the extent to which the researcher interprets data beyond spoken word. The epistemological position for the study has been clarified as critical realism; the remaining two concerns will now be addressed.

A deductive or 'bottom up' analysis is driven by the researcher's theoretical interest and attempts to use a pre-existing frame by which to understand the data. Alternatively, an inductive or 'top down' approach is data driven and minus researcher analytic preconceptions (Willig, 2013). The interview data was initially approached inductively, then screened using a deductive framework generated with themes from the survey analysis. This process was completed

secondary to limit the risk of preconceptions affecting initial analysis. This approach to the data was chosen to increase attempts at generating a comprehensive thematic analysis, and to support the synthesis of both components of the research.

Thematic analysis can also focus on different kinds of meaning. These can be manifest meanings, the explicit content of what has been said, or latent meanings, the researcher's interpretation of what has been said (Willig, 2013). A latent approach to the data was opted for the current study due to an interest in what may be 'unspoken' information during the interview. To enhance credibility of researcher interpretation quotes were included in the write up of the report to demonstrate how conclusions were reached.

2.6.2.4.1 Phases of thematic analysis.

Interview transcripts were analysed using thematic analysis following the six outlined by Braun and Clarke (2006) (Table 12). Examples outlining the process, including coding excerpts and thematic maps are referred to in section 2.7.2.1 (quality assurance).

Table 12

Phases of thematic analysis

Phase	Description
Familiarising yourself with the data	Transcribe data, read and re-read the data, note any initial ideas.
Generating initial data codes	Systematically code interesting features across the data set, collating data relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis.
Defining and naming the themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
Producing the report	Final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing scholarly report of the analysis.

(Braun and Clarke, 2006, p. 87)

2.6.3 Deductive analysis.

Between phase 3 and 4 of thematic analysis the deductive framework created from the online survey was used to analyse the interview data. The process indicated that there were no concepts within the survey data that were not in the interviews and vice versa. Concepts within the interviews were reflected in the survey, however, were mainly restricted to opinions and expanded on in greater detail within the interviews. As such, no changes were made to the potential themes following the inductive analysis.

2.7 Quality Assurance

Quality assurance will first be considered in regards to the quantitative and qualitative components separately before considering quality appraisal of the study as a whole.

2.7.1 Quantitative analysis.

Due to the descriptive nature of the quantitative data checking the survey for face validity is most appropriate. Face validity measures the extent to which an instrument is viewed as covering the concept it aims to measure (Krippendorff, 2004). Usage of the term has been cautioned, however, as the appearance of validity does not constitute scientific evidence (Royal, 2016). Despite critique over assessing validity of an instrument based on appearance, in this instance there is an absence of alternative methods for establishing quality. It is comprehended that face validity can be assumed with reasonable confidence, as the survey gathered data in line with its aims, and did not contradict comprehensive interview data.

2.7.2 Qualitative analysis.

In qualitative research there is no absolute criteria for judging quality, but in order to yield meaningful and useful results it is essential to ensure research is conducted in a rigorous and methodical manner (Attride-Stirling, 2001). Rather than relying on adaptations of quantitative criteria, quality criteria and techniques suited to qualitative research have been developed (Braun & Clarke, 2013). Guidelines for assessing quality often comprise a checklist of criteria or overall characteristics the research should hold (e.g. Elliott, Fischer, & Rennie,

1999). Such guidelines have been subject to critique, however, given the diversity of theoretical approaches adopted over the field of qualitative research, and limited applicability in applying a single set of guidelines to all studies (Reicher, 2000). Braun and Clarke (2006) provide a 15-point checklist of criteria for a good thematic analysis, however, the problem remains with how to interpret guidelines as most are not absolute and are difficult to determine.

Prior to analysing interview data, qualitative data from the survey was coded and organised into themes (Appendix M). This process was not analysed further, but formed a deductive framework along with collating the most frequently selected responses into a table. This process was not subject to rigorous quality assurance given the brevity of responses, but excerpts of data and codes were reviewed in research supervision alongside overall themes upon completion.

2.7.2.1 Trustworthiness as quality assurance.

Trustworthiness is one way that researchers can convince the reader of the quality of their work (Lincoln & Guba, 1985). Guidelines have been developed for demonstrating credibility using thematic analysis specifically, emphasising transparency (Nowell, Norris, White, & Moules, 2017). Criteria for trustworthiness is applicable regardless of epistemological and ontological position due to reliance on methodological arguments and techniques (Green, 2000). This process of establishing quality is also congruent with the critical realist position, which emphasises replicability of research in that researchers are explicit about how data was collected and results drawn (Barker, Pistrang, & Elliott, 2002). The method includes audit trails and triangulation which are also commonly used techniques in establishing quality in qualitative research (Braun & Clarke, 2013). As such, the concept of trustworthiness will be applied to establish quality of the current research.

Lincoln and Guba (1985) define trustworthiness in regards to research by the criteria of credibility, transferability, dependability, and conformability (paralleling the validity and reliability of quantitative assessment). Table 13 outlines the

stages of thematic analysis alongside how trustworthiness is established during each phase of analysing the interview data.

Table 13.

Establishing trustworthiness in thematic analysis

Phase	Means of establishing trustworthiness
Phase 1: Familiarising yourself with your data	<ul style="list-style-type: none"> Prolong engagement with data Triangulate different data collection modes Document theoretical and reflective thoughts Document thoughts about potential codes/themes Store raw data in well-organized archives Keep records of all data field notes, transcripts, and reflexive journals
Phase 2: Generating initial codes	<ul style="list-style-type: none"> Peer debriefing Researcher triangulation Reflexive journaling Use of a coding framework Audit trail of code generation Documentation of all team meeting and peer debriefings
Phase 3: Searching for themes	<ul style="list-style-type: none"> Researcher triangulation Diagramming to make sense of theme connections Keep detailed notes about development and hierarchies of concepts and themes

Table 13 cont.

Establishing trustworthiness in thematic analysis

Phase	Means of establishing trustworthiness
Phase 4: Reviewing themes	<p>Researcher triangulation</p> <p>Themes and subthemes vetted by team members</p> <p>Test for referential adequacy by returning to raw data</p>
Phase 5: Defining and naming themes	<p>Researcher triangulation</p> <p>Peer debriefing</p> <p>Team consensus on themes</p> <p>Documentation of team meetings regarding themes</p> <p>Documentation of theme naming</p>
Phase 6: Producing the report	<p>Member checking</p> <p>Peer debriefing</p> <p>Describing process of coding and analysis in sufficient details</p> <p>Thick descriptions of context</p> <p>Description of the audit trail</p> <p>Report on reasons for theoretical, methodological, and analytical choices throughout the entire study</p>

(Nowell et al., 2017)

2.7.2.1.1 Phase 1: familiarising yourself with your data.

Prior to conducting interviews, an excel spreadsheet was created to track progress in collecting data and was updated accordingly as interviews were completed (Appendix N). Interviews were not transcribed by the researcher and so were read through twice prior to coding for familiarity. All files were named with the corresponding participant number from the excel sheet, a table created to identify each participant number with the service they worked in and level of involvement (Appendix O). Short summaries for each participant were also created capturing the essence of the interview (Appendix P). Raw data were stored securely on an encrypted memory stick and were archived with dates to provide an audit trail. Researchers are encouraged to be honest and vigilant about their own perspectives and pre-existing beliefs (Starks & Trinidad, 2007). Prior to coding, initial thoughts and ideas were documented in a reflective journal (Appendix Q) and discussed in research supervision as interviews progressed.

2.7.2.1.2 Phase 2: generating initial codes.

Transcripts were uploaded to Nvivo and each interview was coded inductively by the primary researcher. Codes were generally completed line-by-line, however, individual extracts of data were coded in as many different themes as they fit in order to maximise depth of analysis. An example of coding can be found in Appendix R. Excerpts of interviews and the corresponding codes were reviewed in research supervision to enhance credibility of analysis. Meetings were recorded using a supervision log (Appendix S) as a means of establishing an audit trail. All data sets were worked through systematically, giving full and equal attention to each transcript. Use of the reflexive journal continued to note relevant concepts to the research question.

2.7.2.1.3 Phase 3: searching for themes.

Codes were initially clustered into similar concepts per transcript and an excel spreadsheet created to identify prominent concepts across all transcripts (Appendix T). Mind-maps were then created for each concept (Examples in Appendix U), bringing together all of the data sets.

At this stage, transcripts were revisited and re-coded using the deductive framework created from the survey data. Pre-determined codes were created for each category in the framework and each transcript was coded accordingly. Discrepancies were also noted, for example, for the code 'inappropriate - requesting or recommending that specific psychotropic medication be prescribed for a service user' it was noted when a participant acted in contrast to this (Appendix V). Similarities and contrasts were noted in the reflexive journal, however, the survey data supported the initial themes and so there were no changes made to the analysis process thus far.

Due to the large volume of data, a further mind-map was created specifically drawing on the research aims to allow salient themes to begin to emerge (Appendix W). The use of diagrams allowed for connections to be made between initial themes and was further enhanced through discussion in supervision. A process diagram was created that was felt to collapse all concepts into over-arching themes, continuing to accurately capture the data.

2.7.2.1.4 Phase 4: reviewing themes.

During this phase, summaries were drafted of themes and subthemes prior to review and discussion in supervision. Amendments to the process diagram were made in accordance with the discussion and review of themes (Appendix X). For example, 'Approaching involvement' transformed into 'Strategy selection' following discussion that this theme better captured the essence of the data. Further clarification of subthemes within 'Forms of involvement' were also discussed and categorised. Investing sufficient time to develop and refine the themes will increase the probability of developing credible findings (Lincoln & Guba, 1985). Coded extracts for each theme and subtheme were reviewed to check for accuracy. To ensure that the themes were reflective of participant voice the raw data was also revisited and read through with the themes held in mind. This helps ensure that all conclusions are firmly grounded in the data (Lincoln & Guba, 1985).

2.7.2.1.5 Phase 5: defining and naming themes.

Detailed analysis was written for each individual theme and subtheme which identified the story that each theme told, whilst considering how each fit within the research questions. Consulting an outside expert can help to determine whether themes are sufficiently clear and comprehensive (King, 2004). A meeting was held with an external supervisor in order to gain an independent review and perspective of the themes. Theme names were agreed as suitable, and a final process diagram was created to visually display the themes and how they interact as a process.

2.7.2.1.6 Phase 6: producing the report.

Once themes were established the report writing process began. Direct quotes from participants are considered essential in good quality qualitative research (King, 2004) and formed part of the write up. All reports were accompanied by a pseudonym to demonstrate that various participants were represented. Findings were synthesised with the survey results and discrepancies discussed. Considerations were made as to the clinical implications and importance of the study findings. Member checking was not utilised due to time constraints of the research process.

2.7.2 Mixed methods critical appraisal.

Consensus on the critical appraisal of mixed methods research is lacking despite availability of several critical appraisal frameworks (Heyvaert, Hannes, Maes, & Onghena, 2013). Heyvaert et al. (2013) reviewed available frameworks and identified two groups of criteria specific to mixed method research: the mixing and integrating of the combined methods, and providing a rationale for conducting mixed method research.

2.7.2.1 Integration.

Integration has been reached during analysis by using a deductive framework created from the survey with the interview transcripts. In this way, results from the first phase are incorporated into the analysis of the second. In addition, a section in the results has focused on synthesising both strands by way of comparison, and hypothesising discrepancies. The manner in which data

support or contradict each other have been considered, and results from both were incorporated into the end process diagram.

2.7.2.2 Rationale.

The core rationale for using a mixed methods design was for complementarity, due to a lack of previous research in the topic area. Use of a survey alone would have provided some insight into the forms of involvement conducted within a relatively large sample, however, would fail to obtain rich data of participant views and decisions. On the other hand, whilst the interviews facilitated collection of meaningful and interesting data, without the larger context of the survey it would 1) have caused difficulties in recruiting a reliable variety of participants and 2) further limit generalisability and provide little information as to what clinical psychologists are doing on a larger scale.

2.8 Service User Involvement

The research project was proposed by the Trent Doctorate's service user panel as a suggested topic. For continuation of service user involvement, a discussion was held with members of the service user panel at the University of Nottingham. General feedback indicated that the panel perceived that clinical psychologists increasing their involvement with psychotropic medication would be preferable. This stemmed from personal experiences of having good therapeutic relationships with clinical psychologists, and more frequent contact than with their psychiatrist. Increased opportunity to discuss medication issues within a trusting therapeutic relationship was identified as preferable by members of the panel.

2.9 Reflexivity

Reflexivity is important in qualitative research due to an ability for the researcher to completely detach from the research, and the manner in which the researcher is implicated in the research and its findings. The product of qualitative research is invariably shaped by the researcher and their position on the given subject. This extends beyond considering personal biases and encourages how personal reactions may facilitate interpretations and understanding of the data (Willig, 2013).

A reflective diary was kept throughout the research process to note down initial thoughts in relation to the incoming survey data, and re-read prior to conducting interviews in order to hold the data in mind. Research supervision sessions were also used to consistently re-visit collected data in order for all data to remain at the forefront and limit the risk of neglecting or forgetting findings.

2.10 Researcher's Statement of Perspective

A statement of perspective can position the reader to the researcher and provide orientation for which to interpret and understand the research analysis (Elliott et al., 1999). This research has been undertaken as fulfilment of the course requirements. My interest in the topic stems from past experience of working in a secure ID service whereby service users resided under a restriction of liberty. At this stage in my career I had limited knowledge about psychotropic medication, reasons for its use, and its effects. I soon realised, however, that the majority of service users were taking several medications. Many service users were unable to articulate their understanding of what medication they were on and its purpose. In some cases, service users refused to accept medication and second opinion doctors were sought for the purpose of administering medication in best interest. I also observed a tendency to use psychotropic medication as an initial intervention, prior to psychological intervention. I started the research with the assumption that the majority of clinical psychologists would be against the use of psychotropic medication, and would seek to reduce its use but find this difficult to put into practice due to power dynamics within the MDT.

3. Extended Results

This section elaborates on results from both the online survey and interview. Additional frequencies from the survey results are provided, additional information on infernal analysis, supplementary quotes to support the interview data, and two case examples of the involvement process.

3.1 Survey Results

3.1.1 Inferential analysis

To investigate the relationship between service worked in and involvement in the last six months, logistic regression analyses were conducted. No assumptions are made about the distributions of the explanatory variables, however, the variables should not be highly correlated with one another as this may cause problems with estimation (Peng et al., 2002). A test for collinearity was found to be low (largest VIF = 1.7) and data was deemed suitable for regression analysis (Appendix Y). Large sample sizes are also required in order to provide sufficient numbers in both categories of the response variable. A general guideline indicates a minimum of ten cases with the least frequent outcome for each independent variable (Statistics Solutions, 2018). Based on this, 60 cases for each category of independent variable were required. Consequently, power was found to be low for some categories (Appendix Z). There were four significant results (Appendix AA) which at 96 tests is the false positive rate expected. Some caution in reporting findings is, therefore, warranted. However, despite being underpowered, one category (participants working in ID services are more likely to request or recommend that a service user be taken off psychotropic medication) had a very small p value which is smaller than expected by chance, increasing confidence in this finding.

3.1.2 Frequencies

3.1.2.1 Recent involvement (*last six months*).

The form of involvement that the majority (81.6%) of participants reported engaging in was reflecting with a service user on their general experience of taking psychotropic medication. This was followed by discussing psychotropic medication issues within individual service user sessions (79.6%) and supporting service users to discuss their psychotropic medication with their

prescriber (72.1%). The option for no involvement at all was chosen least frequently with just 2% of participants selecting this; 98% therefore had been involved in some capacity within their recent clinical practice.

3.1.2.2 *Would do given the opportunity.*

In regards to options selected that participants *would do* given opportunity regardless of their current involvement, the two most selected options were: reflecting with a service user on their general experience of taking psychotropic medication (92.5%), and supporting service users to discuss their psychotropic medication with their prescriber (91.2%); both of which were reflected as being the most popular involvement options within recent practice. Following this, the third highest selected option was engaging in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication (89.1%). There were no participants who selected that they would not have any involvement if given the opportunity.

3.1.2.3 *Three most important.*

When participants were asked to select the three options they felt were most important for clinical psychologists to be engaging in, responses clustered around four which proved to be the most frequently selected: Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication (55.8%), support service users to discuss their psychotropic medication with their prescriber (41.4%), be involved in the decision making process to prescribe a service user psychotropic medication (38.8%) and reflect with a service user on their general experience of taking psychotropic medication (38.1%).

3.1.2.4 *Inappropriate.*

In response to whether participants felt any of the options were inappropriate for clinical psychologists to be engaging in, the most frequently selected response was requesting or recommending that specific psychotropic medication be prescribed for a service user (49%). The second most selected response, however, was that no options were inappropriate (33.3%), followed by

requesting or recommending that a service user be taken off a specific psychotropic medication (26.5%).

3.1.2.2 Discrepancies

Engaging in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication was not voted as one of the most frequent options that participants had been engaging with during the last six months. However, 89.1% reported they would do this given opportunity, and was also ranked as one of the most important forms of involvement. Being involved in the decision making process to prescribe a service user psychotropic medication was ranked as one of the most important forms of involvement (38.8%) but wasn't one of the most frequently selected in regards to recent involvement, and options that would be done given opportunity. Logistic regression analyses were used to explore any relationships between type of service worked in and options for involvement within the last six months selected.

3.2 Interview Results

The themes and subthemes will be expanded on in order to provide additional quotes to support themes and increase representation of participants. In addition to providing further examples, a further critical approach will be taken to the results to add further speculation and consider findings from an alternative perspective.

3.2.1 Conflicts and uncertainties.

There was acknowledgment from participants that dominant medical-model narratives towards understanding and treating mental health difficulties prevailed in society: -

"I think there is a lot of, you know, I think medication, psychotropic medication, but I think medication in general, there's probably an over reliance in our society on that." - Kate

This initially creates a conflict for psychologists, whereby psychological approaches in understanding aetiology of human distress is at the root of the profession. Alice describes this conflict as a “*battle*” as “*people take at face value what medics say about this assumed kind of within person disorder, disease*”. A paradigm conflict exists wherein participants are working in structures that potentially do not align with both their personal and professional views about the experience of human distress.

In addition, the majority of participants recognised that their clinical training course adopted a critical stance towards the medical model, with expectations highlighted that clinical psychologists will take this view forward in practice. Whilst some welcomed a critical ethos, there were mixed views as to whether encouraging such a critical position during training was in fact helpful. Lucy believed that “*a lot of psychologists views are perhaps a little bit ill informed*”, and challenged her course’s critical approach: -

“So I ended up approaching our course director and just kind of saying, look, I’m feeling a little bit uncomfortable that we’re sort of supposed to be learning how to treat people as individuals and not kind of, you know, fit people into predefined categories. And yet, all psychiatrists and psychiatry is evil, and it just didn’t sit well with me.” - Lucy

Lucy makes the interesting point that being “antipsychiatry” in itself is actually at odds with the idea of removing classification, and highlights that negative blanket views towards another profession are unhelpful. Nicole echoes this sentiment, stating “*And we’re not going to be so damning that we’re not going to be prepared to be open minded about the fact that it [medication] can be beneficial to people*”, suggesting that sweeping negative views may do clients a disservice.

Furthermore, Saffron acknowledged that a medical narrative around the understanding of mental health is indeed helpful for some clients, and this is how they choose to understand their difficulties: -

“So it is, for some people, it’s more helpful to think that they’ve got an illness and they need medication. And they take comfort in the fact that, in knowing that this is something that’s recognised, that other people have had and have coped with. And so in that way they might find it quite a comfort.” - Saffron

Conflict arises between expectations set during training to minimise medical understandings, whilst working to maintain personal meanings and narratives for the client. Additionally, Saffron suggests that offering alternative understandings might just serve to cause confusion: -

“I’ve seen people saying, it is really confusing when people have such different stances and I don’t know what’s right and what’s not right.” - Saffron

Saffron continues to say *“I guess it’s, there isn’t a right and not right, there’s just a, what you think and what’s most helpful to you”*. Acknowledgement that psychological approaches are an alternative and not a fundamental answer may serve to increase uncertainty and trepidation around challenging medical frameworks, given that both might be viewed as plausible frameworks for clients in understanding their distress. In addition to the risk of causing confusion, going against societal dominant understandings was noted as a difficult act: -

“Well I suppose it feeds into bigger narratives about kind of like, in society, about what mental illness is and the fact that, you know, it’s a very medical model all the way through, isn’t it? You know, it’s built into the structures, it’s built into our laws and things like this, you know... you’re kind of coming right up against this challenging view, which is widely held in the rest of society. It can make you feel like you’re the odd ball.” - Bradley

Overall, ‘conflicts and uncertainties’ captures the disparity between perceived expectations of the role and feasibility of meeting these expectations in practice. Participants are caught between feeling a responsibility to advocate a shift away

from the dominant medical model, but are left feeling uncertain about doing this due to acknowledgement that medical approaches have a place in mental health, and going against the grain can be very challenging.

3.2.2 Weighing up.

‘Weighing up’ refers to the process of decision making whereby participants consider a variety of factors prior to deciding whether to become involved with a client’s medication. Certain factors were found to either encourage or discourage involvement, and also impacted on the type of involvement.

3.2.2.1 Values driven responses to clients.

During the weighing up process a common rationale for a decision to be involved was based on the value of supporting informed consent, due to this being considered in line with clients’ best interests. Responses based on this value were commonly reflected in terms of feeling a pull to provide information due to clients appearing ill-informed or misinformed about their medication: -

“I don’t think it should be my role but because I don’t feel like, maybe GPs don’t have the time and stuff for all the literature up to date at hand, then I think, obviously, now, in these days, it’s really easy to find information about drugs on the internet. And that most of the clients probably haven’t got access to printers, some of them aren’t allowed to look at the internet. So I feel like then we do have a duty of care really to inform them about stuff.” - Jessica

Despite acknowledgement that searching for and giving information is outside of her role, Jessica feels a pull to respond based on a self-defined “duty of care”. Hayley similarly describes how she feels a duty to ensure clients are well-informed of medication side effects: -

“I do think it’s important for clients to be aware that they could experience some side effects, you know, because it’s making an informed choice and deciding, you know, do you want to put up with possibly feeling more low and more suicidal over the first month? Do you want to put up with

feeling sick or having an upset stomach or having really vivid dreams?” - Hayley

Hayley rationalises involvement based on values of supporting informed consent with a view to protect clients who may be ill-informed of side effect risks. There appears to be a sense of taking on the unpleasant job that has been missed by the prescriber in supplying some of the undesirable information. Indeed, Hayley states: -

“I think one of the things I’ve seen in the medical reviews I attend, is that the medics don’t really talk too much about how it might not help or, do you know what I mean? They don’t seem to talk about the negatives.” - Hayley

Hayley suggests that remaining loyal to values overweighs the avoidance of a potentially negative conversation about unpleasant side effects. This raises the interesting reflection of whether providing negative information is genuinely delivered to support informed consent, or perhaps driven by an alternative agenda to critique and reduce medication.

A lack of clear rationale or observable benefit for the client was a factor that seemed to pull on ethical values for participants to become involved. Bradley voiced his frustration towards long-term use of medication with little clinical need: -

“I guess something that kind of gets my goat a bit is, we’ve got a small population of service users who have been on depo medication for years and years and years, and just been lost in the midst of time, kind of like why they’re on it, what it’s supposed to be for.” - Bradley

Jessica describes how she feels a pull to become involved and raise the issue if medication appears ineffective: -

“Because I feel, ethically, that that’s part of my role really, in terms of if they’re still very distressed, things aren’t working.” - Jessica

However, with no apparent unhappiness on the client’s front and a beneficial medication effect, there is no need to act as Jessica’s values are not impeached: -

“...like I say, they’re happy with it, if it seems to be having the desired effect for them, then fine, there’s nothing that I would, I don’t feel like I’ve got a duty then to kind of highlight anything to them.” - Jessica

Evidence of beneficial outcomes and client satisfaction are, therefore, factors weighed up based around ethical values of ensuring clients aren’t taking medication by virtue of habit, and potentially experiencing side effects with no positive results. Saffron goes one step further by suggesting that withholding medication might be considered unethical if it might have beneficial effects: -

“And, you know, some people think that’s a little bit unethical because it’s like, well if this, if increasing the medication could alleviate some of this distress, then why aren’t we doing it?” - Saffron

This raises an interesting point of how participants largely consider it an ethical obligation to intervene in ways that might reduce medication use, but in fact, Saffron highlights how deterring medication could be unethical by denying access to distress-reducing treatment.

Other than situations of high risk and distress, medication use might also be prompted by belief that it could help a client better access therapy: -

“We’d had twelve sessions of CBT, there hadn’t been any kind of shift at all. And I was wondering, is that just because her anxiety is so, so high, if we sort of are able to reduce that slightly on a chemical level or try to do that, would that mean that she could do some of the exposure exercises?” - Hayley

Lucy described one situation in particular whereby she felt prompting a medication referral resulted in better therapy outcomes: -

“I remember, in particular, one lady who was really struggling to engage with therapy. So we had conversations around, actually, would medication be helpful, in terms of giving her a little bit of a lift, in order for her to then engage? So I then referred her onto psychological medicine and they had some discussions there... she reflected at the end that actually, the medication was the most helpful way of her engaging in therapy. She was sort of saying, that without that, she felt that she would have just continued to see herself as failing because she wasn't able to just engage fully.” - Lucy

In such circumstances, prompting medication (or choosing not to challenge its use) can be viewed in terms of participants feeling it is in clients' best interests in order to access therapy. From a critical point of view, it might be argued that participants use values-based practice in order to justify a variety of actions to best suit their agenda in a given situation. As clinical psychologists, client engagement with therapy is very likely to be considered priority. In order to enhance engagement, it appears that medication use is willing to be tolerated, and encouraged, justified by acknowledging that accessing therapy is in clients' best interests.

Finally, there seemed to be an increased pull to advocate on behalf of clients who may lack capacity, such as individuals with an ID. Nicole makes comparisons between working with individuals who have capacity to make decisions about medication, and those who may not: -

“And it's going to be very hard, unless a client is saying themselves, I don't want to be on this, for you to advocate on their behalf as a capacitous adult that, you know, you shouldn't be on antidepressants really, should you? You don't need these. That's going to be very difficult to influence that individual. You've got to respect what their viewpoint is

on the medication they're taking. Whereas, in LD, we are advocating a lot of the time for that individual, for a lot of our clients.” - Nicole

Nicole appears to adopt the role of benevolent protector advocating on behalf of clients to influence medication reduction, with what seems an underlying assumption that the psychologist knows best. Terminology used suggests it is easier to influence clients who have an ID, raising the question of whether personal views towards medication are actually imposed, but framed as being in clients' best interests.

3.2.2.2 Team context.

When a team was already highly involved with medication and minimising use where possible, there was often little need to be involved: -

“I think because in our sort of, the culture in our team is to generally, if it's deemed to be unnecessary medication or too much of a certain something, then generally, it would be kind of done anyway or we would generally try and work with the patient to sort of decrease the medication as much as possible.... So yes, it's rarely that I need to sort of, feel that it's down to me to kind of intervene, let's say, with something.” - Kate

Kate appears to monitor and weigh up situations as to whether she needs to become involved by judging if she feels comfortable that the team are already acting in line with her values. Having said that, Kate also places a lot of trust within her team about medication decisions reducing the likelihood of involvement: -

“So I think, you know, if the rest of the team feel that it's important or necessary for the client to be on it, then, you know, that would be, you know, that would be sort of fine with me. And if that's, you know, I wouldn't necessarily intervene in any way in those kind of cases.” (Kate)

Kate's trust in her team's judgement may be strengthened by belief that they hold similar values around reducing medication, and so she regularly decides

that there is no reason to be involved. Although, there does also appear to be a sense of relief for Kate in not needing to intervene. As such, there may be an element of justifying inaction by framing the teams' values as consistently in line with her own. Louise similarly describes relief from feeling that she needs to intervene: -

"And again, if somebody is prescribed say, four Diazepam a day and they're taking it every day, four times, you know, I would say, what's going on there? But again, usually, the teams that I work with are really hot on that as well." - Louise

This relief from feeling a need to become involved appears accompanied by a sense of fortune of working within a psychologically minded team, with suggestion that this does not reflect the norm. Having good relationships with prescribers, who are also receptive to psychological input, was reflected as important in being able to become involved and broach conversations around medication. Feeling influential and able to become involved within the team felt like a privileged position: -

"I guess I'm pretty fortunate with the team I'm at, you know, the psychiatrists, they don't throw their weight around too much, you know, they are fairly kind of like receptive to different points of view." - Bradley

Bradley reflected that he feels fortunate that his team context allows him to raise issues and offer psychological points of view, despite having previously acknowledged that doing so is important in his role (*"If the psychologist isn't speaking up and offering a non-medical explanation, then no one else will kind of thing"*). Saffron expresses a similar level of freedom and acknowledges that it is not a given for all psychologists: -

"I've just been in a meeting with some of the psychologists, who feel so undervalued and not respected by psychiatry and by other professions, that I actually felt quite privileged and quite lucky that I'm taken seriously." - Saffron

Saffron's point highlights the impact of the team context in feeling comfortable and influential on weighing up decisions to become involved.

Two additional examples demonstrate the impact of team set up on decisions about involvement. Lucy works in a cancer service and explains how the physical healthcare element reduces opportunity for her to weigh up a need to be involved: -

"So our team is all psychologists. So we, we're embedded within the hospital but we are separate from kind of the medical sides of care, and all the medical side of care is cancer. So it's normally the GP or psychological medicine that would prescribe psychotropic medication. So from that point of view, we don't really have any contact with a kind of wider MDT, to be having discussions about medication". - Lucy

In contrast, Kristy works in a service with no co-located prescriber and regularly has to weigh up decisions about medication given her sole responsibility to prompt medication referrals: -

"Well it's still an MDT, so, obviously, I have a nurse colleague and an OT colleague, so we do discuss clients, you know, in our weekly team meeting. So one of them might suggest medication might be useful. But, obviously, as the care coordinator, you know, it would be my position to request or not request." - Kristy

Overall, participants identified how the team context and service set-up has large influence over opportunities, authority, and requirement to become involved with medication.

Lastly, working in physical health services appeared to add an additional element to which clients might expect the clinical psychologist to adopt a similar role of other medical clinicians. Lucy described how this could potentially deter discussing medication with a client: -

“I’m cautious of not wanting to introduce that kind of expert stance or that sort of continuing that sort of experience that people will have had, where they present with a problem and then the doctor fixes them. So that’s, I don’t think I’ve broached it with anybody myself.” - Lucy

There was also felt to be minimal need for a role in physical health (cancer) services, whereby the use of psychotropic medication risks medicalising normal reactions to a substantial life event.

3.2.3 Strategy re: agenda.

A decision to become involved was underpinned by psychologists’ agendas towards medication and strategy by which agendas were expressed ranged on a continuum from neutral (dropping agenda), to tentative, to challenging.

Despite generally considering herself to be ‘pro-medication’, Lucy felt it was important to represent balanced and neutral views towards medication for clients: -

“...I think, you know, people, people need to make an informed decision about what’s right for them. And I think it’s difficult for them to make an informed decision if the information isn’t being presented neutrally and they’re not being given the pros and cons and different alternatives.”
Lucy

Lucy highlights how expressing personal opinions or attempting to sway a client one way or the other is not conducive to supporting informed decision making. This is interesting in comparison with other participants who advocate that the need for offering potential negative side effects is important for informed decision making. Hayley also reflects on her adoption of neutral strategies: -

“Yes, I think I try not to think about my own experiences of that when we’re having conversations about medication. I’d sort of be thinking more

about what I've seen for other young people, what's been discussed on training.... So I try and be relatively neutral if I can be.” - Hayley

Hayley describes actively attempting to not allow her personal opinions and experiences to influence her conversations about medication with a client. Instead she draws on professional experiences and her knowledge base to try and offer a neutral perspective.

Strategies whereby the agenda was expressed moved along the continuum from tentative, towards more directive and challenging. Hannah explains how she would adjust her approach in relation to the context: -

“...ward round was quite fast paced, so some conversations outside of ward round would be very gentle, very psychologically kind of guided. Whereas, sometimes more, in ward round, it would be, no, I completely disagree with what you're talking about, this is what I think we should do, and it was a really direct conversation.” - Hannah

Hannah judged the most suitable approach by considering which would be best received by her team, alongside other factors such as which would be the most influential within time constraints: -

“I think sometimes, it's knowing the dynamic of your MDT as well, and working with a particular group of people. You kind of know how much time you're going to have, how direct you need to be, or can you be a bit more subtle and gentle?” - Hannah

Whilst all were flexible, some participants favoured one strategy over the other based on past experiences of strategy selection. Alice had been shut down from expressing her opinion historically, and had seen others attempt challenging approaches with limited success: -

“In fact, other psychologists have tried a more direct approach and written reports that then they take to this clinic appointment, as if they're,

you know, going into battle. That doesn't work at all, that doesn't work at all, literally, that doesn't work. And, of course, it won't work at all, will it? Because it's too direct." - Alice

Consequently, Alice generally reported using tentative strategies such as being “playful” and “then start getting them to unpick the story” in order to challenge the use of medication. Hayley also gave examples of tentative strategies she tended to use: -

“I don't know that I've ever sort of stepped in and said, oh why are you prescribing this or sort of being, I can't think of the word, like confrontational about it. But I might have sort of just said, oh, you know, I'm not sure whether medication is going to have any impact on this or I feel like it could be more to do with this type of thing.” - Hayley

In contrast to a gentle and curious approach, Hannah often found using a more challenging approach to be reinforced and so would lean towards this strategy where possible: -

“And sometimes, yes, with a number of people, I remember being told, oh OK, well if you've got an idea, go with that then. So actually, it kind of reinforced my behaviour to be that direct because it was really helpful.” - Hannah

Saffron also reflected the need to be firm to in order to ensure an opinion was counted: -

“And you do need to be a bit more, not feisty, you don't want to cause arguments, and I have actually got good working relationships, but, you know, I've got strong opinions about things and I will say if I disagree with something.” - Saffron

Overall, neutral strategies reflected a decision not to become involved, or to impart information in a neutral way. Tentative and challenging strategies reflect

the expressing of an agenda to influence a clients' medication in some capacity. Participants judged the strategy by which agenda was expressed (or not) based on prior values (acting in clients' best interests), and most suitable strategy in the context of the situation. Flexibility appears to represent participants judging which strategy will be most successful in terms of influence.

3.2.4 Strategy of action.

The process of involvement with medication broadly fell under two subthemes: direct work about medication, and psychological alternatives.

3.2.4.1 Direct work about medication.

Many examples of direct work about medication are demonstrated in previous themes including prompting the idea of medication, supplying information about medication, considering the pros and cons of medication with a client, and discussing a client's medication with the team. Additional examples not already covered will be provided.

In her CAMHS position Alice describes taking on a reflective role by listening to and validating parents' concerns about medication: -

"...with parents then, their child might be on medication or might have been in the past or might become in the future. So, you know, you act as a kind of, a bit of a sounding board." - Alice

Lucy takes on a reflective role by feeding back information in an attempt to normalise side effect experiences: -

"And if people sort of mention side effects and I have had prior experience of other patients saying the same, I might reflect that back, but I wouldn't normally kind of go into, I wouldn't normally go into much detail about that sort of thing." - Lucy

By drawing on her professional experience Lucy provides the client with information about side effects from an anecdotal position. Louise similarly

discussed taking a reflective position, however, gave examples of reflecting on positive effects of medication: -

“I have lots of people say, well I quite like that little blue pill, which is the Lorazepam. And I go, yes, I bet you do, and we talk about that and how reinforcing it is to take it.” - Louise

Whilst much direct work about medication occurred with clients, many examples of involvement were with the psychologist's team. Kristy would interpret the reason behind a certain prescription for other team members working directly with a client: -

“So it's more about, I guess, being able to interpret the information from an assessment point of view, and being able to help staff to understand why different things have been prescribed, rather than giving information themselves. I guess, so yes, this is, you know, it's usually used for this purpose, but, you know, I can find out, you know, more about why for this particular patient.” - Kristy

Kristy comfortably adopts this information giving role, seeing it as important that a client's team are informed about the client's medication. Jessica echoes this sentiment, similarly describing how she will take the time to look up information to share with the team: -

“And this guy went to the doctor, I'd never even heard of the medication, a staff member went with him, because he was saying he's not sleeping, he's the one who's kind of got some symptoms of psychosis. And it might just be from not sleeping and she's giving him something, I don't even know what it is, but once we get the name of that, I will definitely look it up and share that, you know, kind of share that with the team.” - Jessica

Direct work about medication that participants regularly engage in encompasses a wide variety of forms both with clients and the team.

3.2.4.2 Offering psychological alternatives.

Offering psychological alternatives for both understanding and treating distress was felt to be a key part of the role for clinical psychologists. Hannah summarises how this is a key part of her role: -

“I feel like I’ve got a bit of a role to, certainly, to advocate psychological approaches in the first instance. And without doubt, that’s my kind of profession, so why wouldn’t I do that?” - Hannah

Bradley spoke about how using formulation offered a method for shifting away from the medical model without directly addressing medication: -

“You know, just even something like introducing like a common shared language of formulation in the team, you know, just the simple fact that you’re formulating, enables people to talk about the psychosocial factors and not just the medical factors that would be talked about otherwise, yes.” - Bradley

In this way he supports the team to consider wider factors and not focus on a medical disorder. In a more specific example, Alice can be seen to offer a psychological formulation to challenge a young client’s diagnosis of Attention Deficit Hyperactivity Disorder (ADHD): -

“And so I had a view and I talked to the parent about this and I’ve given her stuff that she can read that’s about developmental trauma. Because the way he presents isn’t about ADHD, it’s about developmental trauma. This is a boy that seeks, you know, seeks kind of reassurance on such a high level because he also has a development disability.” - Alice

Alice opens up a new way of thinking for the client’s parents by encouraging them to view his difficulties from a developmental perspective, and further encourages this by providing them information to take away and read. In many cases, offering a psychological formulation served to challenge a client’s diagnoses and negate the need for medication: -

“She had kind of a diagnosis of all sorts of whacky and wonderful things that actually, when we kind of put them into a psychological formulation, yes, it was very complex, but it was all stuff that we could manage in a more psychological way. And it was all things to do with her autism, to do with her sensory needs.” - Hannah

Hannah’s formulation allowed an alternative approach to be undertaken with the client, and also functions to shift staff thinking in considering environmental factors for clients. Louise similarly spoke of how she regularly prompted staff to consider alternative strategies in the context of an overreliance on medication: -

“So I sometimes talk to staff members about, you know, what are you doing instead of giving medication? Because that is something that everyone should be thinking about anyway but it often, depending on the culture of the ward or the person themselves, if they really like it and haven’t got any other coping skills, their first port of call would be to ask for that PRN. Whereas, I might suggest, have we got other ways that we can help someone cope with this in the moment, if that makes sense?” - Louise

Hannah and Louise can be seen to actively take on the role of promoting psychological thinking within the team with the agenda of reducing the need for medication by allowing difficulties to be viewed through a psychological lens. In addition to working with the team, Hannah also described offering psychological alternatives directly with clients: -

“What I have done with quite a few people who’ve raised it with me, is talk about, when they’ve said to me, they didn’t want to be taking it anymore or they don’t think it’s useful, I guess I have encouraged that conversation because then I’ve been able to kind of offer, I guess, the psychological approach.” - Hannah

An example of this in practice can be seen by Kate, below, who offered an account of working jointly with the psychiatrist and client for medication to be reduced and alternative coping skills to be used in its place: -

“So I think, so then it was, there was a sort of work on two fronts, the psychiatrist sort of was working with the client directly, and then I was working on trying to help her, you know, use other techniques more, you know, to not go straight to the medication as a first sort of instance. But sort of think, could I, you know, could I use something else, could I do something else first?” - Kate

This joint approach appeared to work well in empowering Kate's client to utilise new techniques in lieu of medication: -

“So I think, so kind of the medication was reduced and we actually managed to work kind of really well in our sessions, to try and sort of decrease her reliance on the medication and improve her sort of ability to use other techniques to kind of, to manage what she was facing.” - Kate

Kate's example also highlights the importance of supplying psychological alternatives in the first instance, or alongside the reduction of medication. As Louise points out, *“we sort of expect people to take drugs until they can rely not on them”*, acknowledging the need to supply alternative coping strategies before attempts are made to reduce the strategy of medication.

3.2.5 Reflection on strategy.

Following involvement, participants reflected on their strategy adopted and how this might influence future involvement. Bradley said he felt he had only been able to influence medication a handful of times, however, on reflection noticed that he had in fact influenced his team's approach: -

“I guess, you know, being in one team for so long, then I guess, you know, over time, then you do notice that people are starting to challenge things themselves without you there.” - Bradley

By tentatively challenging medication and consistently offering alternatives it appears that his approach has transferred into the wider team and his presence was not always required to continue his work. This influence was not consistent across participants, however. Saffron found that her stance was not maintained in her absence: -

“I’ve seen slight shifts in the nursing staff’s approach. I don’t really think I’ve seen much of a shift in psychiatry. I think when I’m present there’s a definite shift.” - Saffron

These outcomes can be seen in light of how they may challenge or maintain the initial conflicts and uncertainties at the beginning of the process. Bradley may experience reduced uncertainty as a result, with increased confidence that he has an influential role with medication in his team. Saffron, however, may continue to navigate her decisions within a framework of challenges when deciding whether to become involved.

Other reflections included considering suitability of the strategy adopted in light of its perceived effectiveness. Nicole reflects on adopting an intermediary role between a client and psychiatrist, and whose benefit her involvement served: -

“So yes, often, in hindsight, you’ll still reflect on, is that the best approach, is there other approaches? Was that just the easy option for that person and you’ll, you know, I’ll be quick to say, yes, that’s fine, I’ll do that. But actually, does that help my role with that client?” - Nicole

Nicole’s uncertainty seems to stem from conflict arising from the weighing up of her decision; in this instance she became involved at the request of the psychiatrist, however, later reflected on whether this was at the expense of her client. This highlights an ongoing reflective process about whether involvement is fundamentally always in clients’ best interests, or to serve underlying agendas.

In regards to strategy adopted, Alice reflects on her use of tentative approaches to challenging medication: -

“And I just think, what are we doing, you know, tinkering around and tip toeing and avoiding conflict? But the point is this, we work in a social system and there’s a hierarchy, that’s how these systems work. So you don’t want to get a reputation of being the one that’s doing all the challenging, you don’t get very far.” - Alice

Alice appears to feel somewhat stuck with frustration of wanting to act on her values, but acknowledging this can be difficult in her team context. This leaves her reflecting on how her approach might feel ineffective at times, but feels appropriate in the wider context of slowly bringing about change. Alternatively, Hannah reflects on her use of a challenging approach: -

“So I guess one of my reflections has been that I feel I can be really passionate and sometimes that comes across wrong. So I’m trying, I have been trying for a long time, to be a little bit more curious and a little bit more kind of psychologically, you know, that kind of circular questioning type stuff. And thinking about that kind of approach, rather than the more direct approach.” - Hannah

Hannah considers whether using a tentative approach is more helpful in her concerns being taken seriously by her team. Indecision remains as to the ideal strategy for becoming involved with medication, perpetuating uncertainty about the role that clinical psychologists’ have with medication.

3.3 Involvement Process Case Examples

The process of involvement is outlined sequentially for Nicole and Kate to demonstrate the process using case examples.

3.3.1 Nicole.

Nicole works in an ID service and was considered to engage in high levels of involvement.

3.3.1.1 Conflicts and uncertainties.

Similar to others, Nicole reported that her clinical training adopted a critical stance towards medication. Despite experiences during training, she felt that it was important not to be overly critical of medication: -

“I try and be open minded about what people think about it, even though I am mindful that, as a psychologist, I don’t value it at the top of my list of treatment options because, you know, that’s not my professional standpoint, in terms of, medication isn’t the answer. But, unfortunately, it’s very powerful in society, the narrative around certain treatments and medication is seen as a go to for a lot of people to a kind of cure or a panacea to resolve problems.”

Nicole seemed to find a place of acceptance and balance of working with dominant medical narratives given their tenacity. Nicole felt that clinical psychologists have a definite role with medication, however, admitted uncertainty in what this looks like in practice: -

“So that is, it’s quite a big grey area generally, in psychology, in our profession in the UK. That we aren’t prescribers but we do clearly, have a lot of cross over, in terms of thinking about medication, talking about medication and the impact on a client.”

This translated into some uncertainty about the extent of knowledge clinical psychologist require, and indecision regarding the impact of an increasing role on professional identity: -

“And sometimes I probably think to myself, I should be more knowledgeable about medication treatments, but then on the flip side, do I need to be? Because I’m not an expert in that and that isn’t my professional, you know, my subscription and my professional identity.”

Overall Nicole accepts having a definite role with medication, but uncertainty remains regarding definition of this role, particularly in how this fits with a sense of psychological professional identity.

3.3.1.2 Weighing up.

3.3.1.2.1 Values driven responses to clients.

Nicole describes commonly adopting an advocacy role on behalf of her clients, demonstrating a pull to respond and intervene given clients' vulnerability and possible lack of capacity. Her value of advocating in clients' best interests appears to be a strong driver when weighing up decisions to become involved: -

"...if we're going to support this individual or from a, you know, positive behaviour support perspective, or get the, this person's distress levels down, then I need to have a responsible conversation about the fact that just taking a tablet isn't going to necessarily eradicate this or reduce this."

Nicole also feels pulled to intervene when noticing that important information about medication has been missed: -

"And sometimes we've had to step in if side effects haven't been talked about. There might be those times when you think, well hang on, has the person talked through the risks of this? And then they're like, no. And you think, right, I need to get somebody back involved here, because they are actively saying, there's a lack of information here."

She does this confidently without hesitation, identifying this as an element of her role. Whilst it may feel clear that missing information needs to be provided, there is an element of weighing up as to whether it falls within her remit: -

"And we're very clear of not dishing out advice or information that you don't actually have, you know, the professional knowledge, to be asserting more of an information giving, about signposting to where they might be able to find further information about treatment options... So I think it's, I think that's sometimes quite easy, in terms of, that isn't my

role and I don't know the answer to that question, but I can certainly signpost you to who could."

Nicole again appears to navigate this decision with ease. It may be that the weighing up process is somewhat less complex, as Nicole appears acceptant that she will definitely have a role due to her perceived need to advocate in her clients' best interests. The weighing up process is more focused then on whether she feels she has the knowledge to directly intervene, or not: -

"So yes, I think it has its challenges but I think it's knowing your professional identity, isn't it? And knowing your, I suppose your duty of care, where your competencies stop."

Despite acknowledging that the topic can be a grey area, Nicole appears relatively comfortable in her positioning. Consequently, strong values-led practice means Nicole appears to navigate the weighing up process with relative ease.

3.3.1.2.2 Team context.

Nicole identifies increased opportunities for involvement with medication due to the nature of the service and the MDT working closely together: -

"You know, if your client group predominantly goes to a GP and psychiatry is not that available and you don't have a dedicated psychiatry team, then you're probably going to have a lot less opportunity to make, you know, influence those decisions about medication."

Whilst service context offers increased opportunity, strong MDT relationships appear to influence the extent of involvement for Nicole. She describes having good relationships with the prescribing medics in her team, who also value psychology and regularly request input. In addition, Nicole's opinion on medication specifically is also requested: -

“And they will come to us and ask our opinion on diagnosis and medication and whether we agree that, you know, a change is needed.”

This appears to permit Nicole increased authority over having involvement with medication, influencing the ease of the decision making process as to whether she should be involved. Nicole explains how the team context allows her to feel safe to broach medication issues and offer her opinion: -

“I think maybe you probably feel less anxious about having those conversations with people, if you know that’s not going to have negative connotations, or negative repercussions, sorry, or that psychiatry are going to be angry in some way, that you’ve delved into something that they feel is very much their domain. ...I think that enables you to be more open with how you involve yourself in it because you know that’s going to be received positively from an MDT perspective, that you’ve had those conversations.”

The positive relationships and lack of power dynamics support Nicole to feel comfortable having involvement. Being open to involvement and facilitating requests from psychiatry does appear to create some challenges, however, in weighing up whether to opt out of a role: -

“And sometimes I’ve actually been asked by psychiatry, because the client’s not engaging with them, for me to ask them what their thoughts are on their medication, to feed back to psychiatry, if they’re saying they want any medications changed. So sometimes, that’s quite interesting because you think, oh, in some ways you think, oh I’m not sure I’m comfortable with having a conversation about medication.”

Nicole reports tolerating discomfort at times in order to maintain working relationships, highlighting that whilst close working relationships permits greater levels of involvement, it also risks blurring role boundaries. Nicole felt it was important to be clear on where roles end: -

“So I think it’s about kind of how you manage that yourself and how you, how you have those relationships with colleagues, that you are prepared to support them in their work, but still having a clarity of where your role ends. And there, obviously, are grey areas, where sometimes you do feel you are getting more pulled into doing jobs that aren’t ours, and I think that’s wider than just medication.”

This appeared difficult to manage in practice, particularly when involvement invited by the psychiatrist whom it appears important to maintain a good relationship with in order to continue authority around medication decisions. It seemed somewhat easier to weigh up decisions on boundaries when tasks involved a practical element, or it was easier to define the associated professional for the job. Nicole discusses preparing medication for a client’s discharge: -

“So sometimes I’ve had to really take a step back, and even though, obviously, I’m mindful of the risks and I’m involved in risk assessing around how they’re going to have those tablets, I had to let other professionals take a lead, particularly our LD nursing colleagues or the medics here, around how they’re going to get those medication packs in place ready for that discharge plan and that. Because I just feel that that’s well outside of my area of what I should be doing.”

Nicole appears relatively confident in weighing up decisions regarding involvement with clients, however, there appears to be increased difficulty in navigating the role remit with team members.

3.3.1.3 Strategy re: agenda.

Nicole appears comfortable in generally adopting challenging strategies towards medication due to the receptiveness of her team. She confidentially and directly expresses her opinion on medication to her team: -

“So that was really helpful, to say to the psychiatrist, yes, don’t prescribe anything because that really is going to affect our behaviour interventions

at the moment, and we want to be able to prove behaviourally, with the monitoring, that what we're putting in place is having a positive impact."

Nicole also states that the team *"have some quite frank conversations at professional meetings about medication"* suggesting there is a general level of acceptance in adopting challenging positions within the MDT.

3.3.1.4 Strategy of action.

3.3.1.4.1 Direct work about medication.

A large component of Nicole's role includes direct work with medication. Nicole spoke of using information collected from discussions with clients to map onto behaviour charts: -

"So I think that gives us that opportunity, because a lot of time we get feedback about medication, you know, directly, in those conversations, in sessions, or we hear, that someone says, oh their medication's changed and this has helped. So if we're, you know, reviewing and looking behaviourally at things within our behaviour charts, we'd be capturing whether any medication has been changed, whether any PRN's been administered. So we'd be mapping some of that behaviourally on behaviour charts."

Awareness of the medication clients take seems vital to Nicole's role in her ID service in terms of behaviour-mapping. As noted above, Nicole also frequently adopts a role in providing information about medication when this has been missed, and deciding when to signpost to a prescriber: -

"So I might be able to have an open conversation about some of the potential side effects, or advocating that what they're telling me may be a side effect, therefore, we need to talk to psychiatry about this and make more of an assessment of what's going on."

As a final example, Nicole facilitates assessments about medication in order to feed information back to the psychiatrist: -

“So I have actually, you know, had to do a bit of an assessment sometimes with a client, saying, how do you feel about your medication, do you want it to change, do you want to see psychiatry, what are your thoughts? Because they’re not engaging with psychiatry.”

As shown in the examples, direct work about medication forms a core part of Nicole’s role, perhaps emphasised by the nature of the service and collaborative relationship with the psychiatrist.

3.3.1.4.2 Offering psychological alternatives.

Nicole introduces alternative thinking by supporting others to consider the limits of medication, and offering formulation to think about the impact of the wider environment: -

“...we have a duty of care really to think about the wider formulation and to help somebody think about, well if we’re going to support this individual or from a, you know, positive behaviour support perspective, or get the, this person’s distress levels down, then I need to have a responsible conversation about the fact that just taking a tablet isn’t going to necessarily eradicate this or reduce this.”

In addition to offering psychological formulation, Nicole gives examples of activities such as training to support the implementation of psychological techniques. Given the nature of the client group, offering alternatives generally appears to be supporting staff or carers to adopt different approaches to working with the client: -

“And we need to think about, you know, other solutions, or other, you know, other skills or options that the care team can put in place, so they feel more equipped to deal. And sometimes that comes down to training and saying, well we need to offer some support training here or challenging behaviour training, because they, you know, they are heavily reliant on a PRN, you know, type protocol, rather than actually actively

thinking about internal or external factors that might be contributing to that person's presentation."

A role in supporting others with psychological techniques in lieu of medication is clearly considered an important aspect of the role for Nicole. She suggests that it *"can be very disempowering... for people just to be taking tablets and not feel they've got any other way to cope with the distress"*. Nicole spoke positively of offering alternatives and did not highlight any barriers in doing so, perhaps facilitated by her status within the team context.

3.3.1.5 Reflection on strategy.

Nicole reflected that she would not change the role she currently adopts with psychotropic medication, although felt ambivalent about whether she would like to gain further knowledge to inform practice. It was discussed how additional training may enable increased confidence with involvement in some instances: -

"I suppose sometimes I've been mindful about how much to delve, if I think I don't, it's making me sound unknowledgeable about treatments or medication, or I suppose if it links to certain conditions that I think, we should know more about that."

This suggests Nicole is considering opportunities for increased involvement, however, she also appeared reflexive of whether at times her active role was perhaps not always most appropriate. This is particularly the case when working in an intermediary role for the psychiatrist: -

"But then, yes, on the flip side you think, should I be doing that? Should I be delving into asking a client about their medication because does that confuse the issue for them? So yes, often, in hindsight, you'll still reflect on, is that the best approach, is there other approaches? Was that just the easy option for that person and you'll, you know, I'll be quick to say, yes, that's fine, I'll do that. But actually, does that help my role with that client?"

Nicole can be seen reflecting on whose benefit her involvement is for, questioning whether the function is to support her colleague or her client. These reflections lead back into 'contexts and uncertainties', whilst ambiguity around the definition of the role remains. Despite continued uncertainty, it is evident how engaging in reflective practice on involvement might influence Nicole's practice in future.

3.3.2 Kate.

Kate works in an eating disorder service and was considered to engage in low levels of involvement.

3.3.2.1 Conflicts and uncertainties.

Kate began by stating that she felt there was a general reliance on medication within society, and it was often prioritised over psychological therapies: -

"...and, you know, and I think there is a lot of, you know, I think medication, psychotropic medication, but I think medication in general, there's probably an over reliance in our society on that. And I think, you know, as a psychologist, I would like to see kind of more people being able to use other methods, you know, other techniques and all psychological therapies instead of medication."

This hope for therapies to be used instead of medication suggests potential opportunity for involvement, however, Kate expressed uncertainty around clinical psychologists having involvement with clients' medication due to being trained in an alternative role: -

"We, you know, we are trained in sort of other ways of working and I think if we, let's say, if we kind of delve too much into conversations about medication, it kind of dilutes, maybe not necessarily dilutes, but, you know, it kind of, it might be a bit confusing, if that makes sense."

Kate expressed concern that role blurring could be confusing for others and appeared to err on the side of caution. She admitted that a role with medication

was “hard to define” and seemed undecided about whether there should be a distinctive role even with further training: -

“I mean I think generally, as psychologists, I think we don’t, I kind of wonder whether it’s important for us as psychologists to do that, well to, to engage too much with, because I think we would have to either be psychiatrists or, you know, I’m not sure how much, you know, how much, we would have to have a huge amount of training. But then a little bit of training, again, I think might be problematic... although on the other hand, maybe a little bit of training would, yes, might help.”

Despite acknowledging that medication can be overused and she would like to see increased use of psychological therapy, Kate expresses ambivalence as to what a clinical psychologist’s role with medication should look like.

3.3.2.2 Weighing up.

3.3.2.2.1 Values driven responses to clients.

Kate states that she would be inclined to query medication use if she felt that it was not required: -

“I wouldn’t necessarily, you know, unless I sort of, I think that they definitely shouldn’t have that or they definitely don’t need to be on a huge amount of medication, let’s say, because they’re doing quite well.”

Whilst she states that in certain instances she would query its use, overall Kate appears to take a cautious approach in weighing up her decisions to become involved and carefully considers where her remit ends. She explains the extent to which she considers her role: -

“I don’t think it’s, you know, it’s within my role to discuss medication in any detail. I could, you know, I can sort of emphasise and, you know, do all our sort of soft psychological skills around it, but I wouldn’t advise or I wouldn’t, you know, talk about what they should do, you know, apart

from... it's best to discuss it with your GP if it's an outpatient or with our psychiatrist if it's an inpatient."

Kate weighs up her decision based on what seems to be an empathic pull to respond in some way, with boundaries she has defined. Despite holding firm boundaries, Kate is inclined to find a way to become involved and engage her client in a discussion about medication, suggestive of a values based response of care and responsibility for the client's wellbeing. Kate also described an incident of intervening due to risk: -

"There was this one case when I needed to sort of intervene because the patient had expressed some suicidal ideation, and I knew that they were on a lot of medication. And it wasn't, there wasn't a sort of, you know, they didn't have, it wasn't sort of, it was a risk but it wasn't a sort of, they didn't have a concrete plan. But they sort of said, that if they were to act on their thoughts they would use the medication that they had."

In this instance Kate was driven to respond by her values of maintaining client safety, and consequently telephoned her client's GP in order to communicate her concerns.

3.3.2.2.2 Team context.

Kate described her team as having a focus on medication reduction, primarily due to the additional health risks when working in eating disorder services: -

"...the culture in our team is to generally, if it's deemed to be unnecessary medication or too much of a certain something, then generally, it would be kind of done anyway or we would generally try and work with the patient to sort of decrease the medication as much as possible. It might be because it's, you know, the physical health of our clients as well, you know, it can be hugely affected by it. So I think it's sort of, naturally, the drive is to kind of bring that down anyway."

This alleviates Kate from having to make a decision about involvement, given that the team ethos is dominantly in alignment with values about minimising medication use.

Kate expresses a general sense of hesitancy in regards to weighing up involvement: -

“So a lot of the meetings, I’m there when the medication is discussed, although I wouldn’t, I wouldn’t really comment very much on that because there are psychiatrists, prescribing nurses there, that know a lot more about medication than I do.”

When weighing up her decision it seems that Kate is often more swayed by the anxiety around having little knowledge in comparison to her team. Kate justifies regularly not being involved by trusting her team’s judgement: -

“So I think, you know, if the rest of the team feel that it’s important or necessary for the client to be on it, then, you know, that would be, you know, that would be sort of fine with me. And if that’s, you know, I wouldn’t necessarily intervene in any way in those kind of cases.”

As such, Kate often appears to decide not to become involved based on belief that the rest of her team are already working in client’s best interests, and there is no conflict with her values. The set-up of her team, and the reliance on other professionals to address medication issues reduces opportunity for Kate to have involvement: -

“I think if, let’s say, I think it’s because, it’s probably more important for a psychologist if they are the only people that see a patient... if I would be the only person seeing somebody, then, obviously, I would be bringing that probably more frequently.”

It is unclear on how Kate would respond should she face a situation that provoked a strong reaction in line with her values, as Kate is often relieved from involvement due to the nature of her team context.

3.3.2.3 Strategy re: agenda.

Whilst Kate initially stated that she felt medication was often used over and above psychological therapy, she does not often express this agenda and if she does, a tentative strategy is used. Kate describes her reaction to perceiving that a client was taking a lot of medication: -

I think sometimes, I mean sometimes I think, I mean there is generally, you know, if somebody's on a lot of medication, I might, you know, I might sort of say that, but yes, I think, it's difficult.

Kate's tentative language is suggestive of wishing to query medication use but perhaps not feeling confident enough to take a challenging approach. Kate gives a further example of attempting to postpone prescribing: -

"I mean sometimes there might be cases when, let's say, we're thinking about starting psychological therapy with a patient and, you know, I have assessed them, and they seem sort of very, very poorly still. So I would say, maybe it's not quite the right time yet because they don't seem to be able to sort of concentrate or, you know, they're kind of, they're not engaged, they're kind of too withdrawn or something like that, for that particular type of work."

Kate describes how she gently proposes reasons as to why it is not an appropriate time to prescribe medication for a client. In doing so she expresses her agenda in a tentative manner.

3.3.2.4 Strategy of action.

3.3.2.3.1 Direct work about medication.

Kate described how she would sometimes bring medication related issues to her team for discussion: -

“I mean sometimes if I, let’s say, I’ve got, if a patient would sort of tell me that they’re struggling with something, some medication or something like that, then I would sort of pass it on to the team and then they sort of discuss it in that manner.”

As such, much of Kate’s direct work with medication was in passing on concerns rather than directly addressing issues with clients. Kate did provide some examples, however, of direct work that influenced medication a client was taking. One example was with a client in her practice: -

“So we had a chat with, I had a chat with our psychiatrist about that and the use of medication, and encouraged her to discuss the medication with our psychiatrist.... so kind of the medication was reduced and we actually managed to work kind of really well in our sessions, to try and sort of decrease her reliance on the medication and improve her sort of ability to use other techniques to kind of, to manage what she was facing.”

In this case Kate prompted the idea of medication reduction and worked jointly with the psychiatrist and client to manage this. On another occasion, Kate contacted a client’s GP to offer medication-related advice: -

“So then sort of I did contact the GP to let them know about the sort of, to kind of lower the risk and, you know, the problem that, potentially, it’s either that, you know, they really, they didn’t necessarily need the medication, or maybe they did need it but they weren’t using it properly, so that’s why it wasn’t working anyway.”

Despite lower levels of involvement, there are still clearly situations whereby Kate feels a pull to respond and works to influence prescribing.

3.3.2.3.2 Offering psychological alternatives.

Kate felt that offering psychological alternatives was an important role, not just for herself, for the psychologists in general: -

“Yes, I mean I think in terms of, I think, yes, I think as psychologists probably we do have a role in, we have a big role in promoting psychological approaches to mental health. And sort of thinking, sort of maybe showing examples of when it can be used as an alternative to medication.”

Despite considering offering alternatives as important, Kate actually perceives her contributions as being an addition to medication rather than alternatives per se: -

“I think what I usually do in a sort of, in this kind of setting, is generally sort of provide an alternative, I guess, to medication, and think, sort of say, OK, well on top of that, maybe we could do this and this and this, let's say.”

Offering additional ideas appears in line with the tentative strategies Kate commonly appears to adopt, ensuring that psychological ideas are proposed without directly challenging use of medication. Kate regularly considers medication use from a psychological point of view: -

“It's more about the meaning of the, let's say, if they need to be on the medication but they sort of question how, you know, how it impacts them. And it can maybe have a, you know, it might have a bearing on the formulation. So I would kind of think about how they feel about this from the sort of psychological point of view.”

Kate engages with her clients in terms of thinking about the impact that taking medication has on their identity, offering a unique reflective space without necessarily challenging or influencing its use: -

“Because sometimes that affects a lot, you know, the identity of people. Like I’m somebody who needs to be on a very strong sort of medication, let’s say, and, you know, and often, they can want to talk about, they may want to talk about that. So I can help them with that, to think about how it impacts sort of them as people.”

Furthermore, Kate formulates medication use in terms of the impact that it might be having on a client’s ability to progress and engage in therapy: -

“I can think about, is somebody who’s been an outpatient in the sort of service, and she was on a lot of anti-anxiety medication. And she sort of, she mentioned to me that she really needed the medication, she felt she needed the medication because it sort of made her sort of more able to sort of resist the sort of negative thoughts from directly about sort of eating... from a psychological point of view, I was worried about the sort of completely external loss of control, in terms of being able to manage her thoughts.”

By offering an alternative understanding for the client’s difficulties Kate was then able to engage in some of the direct work about medication discussed above, whilst supporting her client to use alternative coping strategies whilst reducing their medication.

3.3.2.4 Reflection on strategy.

Kate reflects by considering how despite having strong opinions, she feels comfortable adopting tentative strategies given the knowledge she currently holds: -

“I think I do have a strong sort of opinion that it’s, you know, I try not to kind of get too much into it. Because I think it’s, you know, the different things will be right for different people, and I think if I’ve, without sort of too, without too detailed knowledge, I think I wouldn’t want to, you know, say, oh, you know, this is right or wrong. Because I think it really depends on who it is and for some people, you know, some people will

need medication, some people won't necessarily. But it's not up to me really to decide which is which really."

Kate's reflections express continued ambivalence about her role with medication; she clearly feels strongly about its use and becomes involved on occasion, but does so cautiously due to ongoing conflicts and uncertainties about the suitability of this role.

4. Extended Discussion

This section elaborates on the discussion provided in the journal article. Study findings are considered in context to relevant literature and theory, strengths and limitations of the study are discussed, before outlining clinical implications and recommendations for future research.

4.1 Findings in Relation to Previous Literature.

VandenBos and Williams (2000) found that almost all psychologists in their study were involved with medication in some capacity, a finding that was also reflected in the current study. The most common forms of involvement psychologists were undertaking did differ between studies, however, it is important to note that options available within both surveys varied. In the previous study, psychologists were most frequently referring a client to a prescriber, recommending a medical evaluation following assessment, and discussing changing a client's medication with their prescriber. These actions predominantly serve an agenda of supporting medication use, however, in the present study roles of a more reflective and discursive capacity were assumed. Most frequent forms of involvement in the current study were reflecting with a client on their general experience of taking medication, discussing medication within individual sessions, and supporting clients to discuss medication with their prescriber. It is important to consider differences in cultural and healthcare context when comparing results. Prominent difference in the treatment patterns of psychotropic medication exists between the US and Western Europe, with increased use in the US (Zito et al., 2008). Divergence in rates can be accounted for by difference in healthcare funding (King, 2001), policies regarding drug advertising, diagnostic classification systems, and cultural beliefs regarding the role of medication for emotional and behavioural treatment (Zito et al., 2008). Despite cultural differences, only a small proportion of UK psychologists felt it would be inappropriate to refer a client for medication (6.1%) or discuss changing a client's medication with their prescriber (3.4%) with many reporting they engage in these roles.

Within context of emerging professional critical publications towards the medical model, it was anticipated that findings might represent a largely critical stance erring away from supporting its use. Indeed, the recently published PTM framework advocates the movement of mental healthcare beyond medicalisation and diagnostic assumptions (Johnstone & Boyle, 2018). Declining to support medication use was, however, not found to be the case. Just under half (49.7%) of survey participants reported making referrals to a prescriber for medication, and slightly fewer were involved in the decision making process in prescribing a client medication (44.2%). Vandembos and Williams (2000) offer little speculation of psychologists' agendas driving their involvement other than suggesting that knowledge of medication may help in understanding the whole person, and support career progression into new roles. Interview data from the current study allows insight as to clinical psychologists' decision making, revealing that whilst medication was not valued as a first-line treatment, prompting its use was driven by responses to client risk and distress, and with hopes of supporting engagement with therapy. These findings also demonstrate the value of the mixed methods approach in providing context and understanding to participants' rationales behind involvement.

Study findings were also congruent with roles proposed by Houghton (2016) who articulated that clinical psychologists were well placed to hold discussions about medication with clients, provide balanced perspectives to medical discourses, and explore the psychological meaning of taking medication. Thematic analysis identified that the sampled clinical psychologists are already engaging in these practices. A form of involvement perhaps unique to clinical psychologists was in using knowledge about a client's relationship with medication to aid formulation and understanding as to how this impacts on client identity and coping styles. These findings support the notion that clinical psychologists are well placed to offer such reflective conversations, an aspect that seems unique to the role.

4.2 Findings in Relation to Theory.

There is limited research with which to compare study findings with. Nevertheless, considerations can be made with regards to previous theories

discussed in the extended background. It was anticipated that clinical psychologists may not traditionally identify themselves as having a role with medication. Role ambiguity was hypothesised due to encouragement from professional networks to work beyond the medical model, but a lack of clarity about expectations on how to manage this. Role ambiguity was extensively expressed, as participants acknowledged that they perceived themselves as having a role, but found this difficult to define and described many 'grey areas'. Role blurring was also apparent, evidenced by many participants engaging in roles they considered beyond their remit, but felt were missed by other professions. This included acting on behalf of a psychiatrist to question a client about their medication when the client disengaged from psychiatry, and seeking information to supply to a client when a GP had not provided this. Concerns associated with role blurring have been highlighted as losing a sense of professional identity (Brown et al., 2000) and a loss of efficiency due to operating outside areas of expertise (Wall, 1998). During the weighing up process concern was expressed about the risk of being perceived too closely to psychiatry and blurring role boundaries. Participants attempted to balance maintaining professional identity as a psychologist, alongside a pull to respond and become involved with medication to support clients' care. This role blurring resulted in feelings of discomfort and uncertainty for some, with little strategy available for managing and alleviating this.

4.2.1 Triangle of responsibility.

The triangle of responsibility model highlighted the uncertainty clinical psychologists' face when making a judgement about becoming involved with a client's psychotropic medication (Schlenker et al., 1994). Due to professional identity, perceived limits of control, and ambiguity about a connection to medication, conflicts around existence of a role were evident. The model proposes that responsibility is the adhesive that connects an individual with an event and a set of prescriptions for conduct, and responsibility increases via strengthening of the three linkages of the triangle. Prior to conducting the research, it was anticipated that the linkages were likely to be weak, resulting in decreased responsibility for involvement with clients' medication. Study findings contradicted this hypothesis, however, with many participants reporting high

levels of responsibility to intervene and considered many actions to be within their 'duty of care'. The triangle will now be considered again in light of findings.

4.2.1.1 Identity-prescription link.

The identity-prescription link refers to the extent to which the prescriptions are perceived as applicable to the individual by virtue of their characteristics and roles. Role ambiguity and lack of clarity about the relevance of involvement to psychologists' identity serve to weaken the link. Schlenker et al. (1994) suggest that the link is strengthened by a sense of purpose and direction. This may account for participants' involvement given that actions were driven by a strong sense of values. A sense of purpose and agenda for involvement may strengthen clinical psychologists' perceived identity with medication, thus increasing responsibility to become involved.

4.2.1.2 Identity-event link.

The identity-event link is the degree to which an individual appears connected to the event; this may simply be due to their group membership, or the extent to which they have personal control over the situation. The extent to which participants felt they had influence and personal control over decisions regarding clients' medication varied. However, little control also did not seem to deter participants from continuing to become involved. In situations whereby participants did not feel they had influence, an alternative strategy would be adopted following reflection on outcome of prior strategies used. As such, a degree of personal control remained even if this was to influence change in smaller, or different ways than previously considered. Additionally, when involvement is validated and met favourably, this may serve to increase perception of personal control and strengthen this link.

4.2.1.3 Prescription-event link.

The prescription-event link refers to the extent to which clear rules and expectations governing the prescription exist. Despite lack of clear guidance, on the whole participants were not deterred from involvement. This link presents as most difficult to account for in regards to study findings. One explanation is that responsibility is increased via the other linkages, and so action is taken despite

a lack of clear rules. Alternatively, self-confidence as a result of certainty about goals is suggested to increase this link (Schlenker et al., 1994). Although there may be no rules governing actions, participants did appear to have goals in mind as a result of their involvement; often to influence prescribing in some capacity. Such goals may increase a sense of responsibility, and actions are then weighed up and navigated in absence of clear rules.

4.2.1.4 Triangle of responsibility summary.

Study results identified that participants do view involvement with clients' medication as part of their role. Goals that are driven by values appear to strengthen the links within the triangle, and create a sense of responsibility that leads to action, despite role ambiguity.

4.3 Discussion of Issues Arising from Results

4.3.1 Online survey.

There were some discrepancies within the online survey that are important to consider. Engaging in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication was not voted as one of the most frequent options that participants had been engaging with during the last six months. However, 89.1% of participants reported they would do this given the opportunity, and this was also ranked as one of the most important forms of involvement. In addition, aiming to support informed decision making was identified as a key driver for involvement within interviews. This may not be occurring as frequently in practice due to a lack of perceived knowledge or confidence in supplying information. Indeed, fears of appearing unknowledgeable and overstepping boundaries were noted within the weighing up process.

Additionally, involvement in the decision making process to prescribe a service user psychotropic medication was ranked as one of the most important forms of involvement (38.8%) within the survey, but wasn't one of the most frequently selected in regards to recent involvement, or if given the opportunity. This again may reflect similar concerns around knowledge, or difficulties within the team context in the practicality of being involved in such decisions due to power

dynamics. These results suggest that many clinical psychologists believe there is an important role to help clients consider medication decisions, and in being part of the decision making process. However, factors are impeding action during the weighing up process, leaving many feeling unable to adopt a role in these circumstances.

It was found that participants working in CAMHS, ID, and services which fell under 'other' were statistically more likely to have been involved in the decision making process to prescribe a service user psychotropic medication, compared with participants working in alternative services. Consideration as to this phenomenon for participants working in CAMHS and ID services has been considered in the journal paper. Reasons behind these differences are difficult to account for with participants working in 'other' services, given the diversity of services noted (eating disorders, neuropsychology, forensic, perinatal, early intervention in psychosis, military mental health, and occupational health). Participants working in services which fell under 'other' were also statistically more likely to have used psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects. This was not a form of involvement discussed in interview, but may well reflect participants working in neuropsychology services.

4.3.2 Interviews.

Rationale for involvement was commonly reported to be due to working in clients' best interests. By virtue of its true definition, best interests refer to the requirement of making a decision on behalf of an individual who lacks capacity (British Psychological Society, 2010). Participants are not describing the act of conducting formal capacity assessments, however, but assuming that they know what is best for the client. More specifically, an assumption is usually being made that medication use is not best for them. It is questionable, therefore, whether utilising opportunity to provide potential negative consequences of medication, or challenging medication use, is precisely working in clients' best interests or in the interest of the psychologist's agenda. This may potentially stem from assumptions that psychological agenda cannot do any harm, but medication can.

4.4 Strengths and Limitations

A key strength of the study was the mixed methods approach used to gather and analyse the data. The online survey is the first attempt to gather data about clinical psychologists' involvement with clients' medication within the UK. The mixed method approach is considered a strength given that the survey data is limited to descriptive information with minimal inferential analysis, which would have been a limitation of using only the survey. The qualitative analysis provided context and understanding behind reasons for involvement (or no involvement) and is the first known study to ask clinical psychologists about both their views towards, and involvement with medication. This study has revealed some insights into how clinical psychologists perceive their roles. This is important in context of the changing profession, particularly with recent movements towards the prospect of psychologists prescribing (British Psychological Society, 2018).

The recruitment strategy for the online survey aimed to sample a representative proportion of clinical psychologists. It was not possible to attain figures depicting the percentages of clinical psychologists working across different service setting within the UK. Consequently, it is difficult to ascertain sample representativeness. The largest proportion of participants worked in adult mental health, which may be representative of a higher frequency of such services in the UK. The survey did not aim to recruit a minimum number of participants; it is unclear as to whether extended recruitment may have added value to the results, however, no strong evidence to suggest this would be the case. Restrictions on recruitment sampling times were required to be made for practicality reasons.

Due to the nature of the topic it is important to consider the potential impact of self-selection bias. Attempts were made to minimise this by encouraging all who met selection criteria to take part regardless of views and experience. The spread of responses and balance of views suggests that this was at least in part successful. The sampling strategy for interviews was devised to represent a variety of opinions, services, and reported levels of involvement with

medication. Interview data largely supported survey findings, suggesting that participants interviewed were likely to be reflective of the wider sample.

It is important to consider the strengths and limitations of the instruments used. The online survey was in part based on one used in a previous study which was not created with rigour (VandenBos & Williams, 2000), and was largely adapted by the researcher. The online survey appears to hold face validity due to generating responses relevant to the research question, plus additional information within the free-text responses alleviating restriction. The survey appeared to have fair accessibility, evidenced by the response rates. The interview schedule was created solely by the researcher; piloting its use provided insight as to whether questions were appropriate and sought responses relevant to the research aims.

One limitation of the study was lack of a second coder when analysing the data, which is considered good practice (Braun & Clarke, 2013). Although only one researcher coded all of the data, excerpts were checked by a research supervisor multiple times during research supervision. The process has also been made as transparent as possible (see quality assurance section 2.7) in order to enhance validity.

4.5 Clinical Implications

The study findings have several clinical implications, and are timely in relation to the recent advancements of the BPS proposing a task group for considering prescribing rights for clinical psychologists. Whilst this study did not focus on the issue of psychologists gaining prescription privileges, it adds to the debate by uncovering clinical psychologists' views towards use of psychotropic medication generally, and roles that are already being adopted in practice.

Professional guidance and/or a position statement are suggested based on current study findings. This would provide greater clarity on roles with medication for clinical psychologists, other professionals, and the public. The reality of what such guidelines would look like in practice, and the challenges in creation need to be considered. Currently, there is divergence in training on

psychotropic medication delivered on clinical training programs and, therefore, inconsistency in pharmacology knowledge held. There is propensity to consider the level of knowledge considered appropriate for clinical psychologists to hold, and for training programs to account for this. Study findings suggest that despite little or no training, clinical psychologists are involving themselves with issues relating to clients' medication. Increased focus during training could serve to support in making these approaches better-informed and more consistent. If the BPS decide to move forwards with psychologists gaining prescription privileges, additional training will be required for those wishing to gain this status. This may reflect an acceptance that the profession as a whole should be more informed about medication, and training programs may incorporate increased teaching in line with the development of the profession.

Similar to the published recommendations on moving beyond diagnosis, overarching guidelines on working with issues related to medication may help provide clarity for clinical psychologists on roles with medication. This may have the advantage of backing the roles that some clinical psychologists are already undertaking, or helping others re-evaluate their role and increase confidence in involvement with medication. Many weighed up decisions about involvement based on team context amid concerns of not being taken seriously by other clinicians, or power dynamics that may prevent involvement. Greater clarity on role has potential to improve team working and promote consistency in approach. Randall-James and Coles (2018) explored clinical psychologists' accounts of working beyond diagnosis and found that many faced challenges in the implementation of working towards a paradigm shift. The authors speculated that this may relate to uncertainties about how to offer alternatives to diagnosis, and highlighted a danger that such a shift may remain aspirational rather than applied in practice. Guidelines outlining how clinical psychologists may become involved with medication may, therefore, be helpful, as opposed to non-specific recommendations that involvement may form part of the role.

4.6 Recommendations for Future Research

The current research explored clinical psychologists' views towards psychotropic medication to an extent, but did not focus specifically on how

views develop and change over time; an area which may be explored in future research. The majority of participants discussed how professional experiences had shaped their views and involvement, however, little is known about personal use of psychotropic medication and how this may influence views and involvement. Within the current study sample one participant reported using psychotropic medication in the past, and a second reported a family member being prescribed psychotropic medication. Future research may wish to consider how personal experiences affect involvement, particularly if personal experience causes a shift in views.

Future research may aim to expand on the current research findings by working towards proposed guidelines to support clinical psychologists in navigating issues relating to medication in practice. One proposed method of working towards establishing guidelines is by use of the Delphi expert consensus method. The Delphi method is a systematic way of determining expert consensus on a given question, determining collective values, and defining concepts (Jorm, 2015). Furthermore, consensus methods have utility in developing clinical guidelines within healthcare (Murphy et al., 1998). This would provide opportunity for a panel of clinical psychologists to have input and reach consensus on appropriate guidance to aid working with psychotropic medication.

5. Critical Reflection

This section critically discusses some of the issues and challenges raised by this research study. Extracts from the reflexive diary are included to demonstrate decision making and offer reflections that occurred throughout the research process.

5.1 Conceptualising the Research

The research project was an idea proposed by the service user panel who work with the Trent Doctorate in Clinical Psychology. I was drawn to the idea based on a personal interest in critical literature towards psychotropic medication, stemming from working in a secure mental health hospital. As an assistant psychologist I began in what I now consider quite a naïve position, accepting psychotropic medication as being somewhat of a cure, given my past support worker experiences of seeing it used as the sole method of treatment. I saw many of the clients in the hospital being prescribed various medications and the frequent use of PRN¹². On some occasions second opinion doctors sought to prescribe medication against a person's wishes. I began taking an interest in critical reading about psychotropic medication, particularly written by other psychologists such as Lucy Johnstone and Peter Kinderman. I started to wonder about whether psychologists should have more of a role in challenging the medically dominant model of mental health. Following selection of the topic idea, I spoke with some of the service user panel members to ascertain their reasons behind suggesting the topic. They suggested that the idea stemmed more from ideas around convenience, due to the increased frequency of contact with a clinical psychologist compared with a psychiatrist. It was also felt that better-quality therapeutic relationships were built with psychologists, and it would be helpful to be able to discuss issues with medication in this forum. This helped me to widen my thinking around all kinds of possible roles clinical psychologists might adopt with psychotropic medication, and not necessarily a solely critical or challenging stance.

¹² Medication use that is proportionate, reasonable, and necessary

5.2 Decisions about the Research

Decisions about the research design were developed through research supervision, and feedback from research panel presentations and protocol submission. The project was initially designed to be an interview study, but following feedback from research presentation panels it was decided to incorporate an online survey and use a mixed methods approach. This was due to a lack of previous research in the field, and reflection that an online survey would be helpful in giving a 'flavour' of wider current involvement. I decided to seek only university ethical approval and not recruit via the NHS in order to save time on the ethical application process. I reflected in my diary that *"I'm worried in case I get a poor response rate and should have taken the time to try and get NHS ethics sorted"*, however, the recruitment strategy proved successful in gaining a suitable number of participants.

5.3 Reflections on the Recruitment Process

Overall, I feel that my recruitment went very smoothly and I did not encounter any problems in attaining a suitable sample size. I felt very lucky, especially with knowledge that fellow colleagues were having increased difficulty with recruitment, yet continued to experience some anxiety in a 'it's too good to be true' sense. Despite having a research plan, I came to realise at many points along the way that perhaps I had not thought certain aspects through in the detail required. I struggled with the concept of feeling anxious that I was not rigorous in my research skills, but remaining flexible where appropriate. Much of my anxiety stemmed from limited confidence in my research abilities, feeling relatively inexperienced in this area: -

"My survey has now been live for over a month. I have 98 responses currently which is amazing! I still have another two months to go, too. Lots of people have consented to follow up interviews also which is fantastic. I had a research meeting the other day and discussed how things are going so far, and some of the decision making regarding the sampling for interviews. I reflected on my worry that I felt like I was kind of making it up as I go, and my plan was a bit woolly. My supervisor helped me realise that it's OK to be open minded about things at this

stage, and as long as I have a rationale behind all of my decision making then it's OK." (26th February 2017)

I continued to recruit participants for interview, again without facing any difficulties. I felt that the interviews went well and I became more comfortable over time in engaging with participants, and following up on details they had said. Reflection on the researcher role in the generation of data is crucial due to the inevitable power dynamic created between researcher and participant. As the researcher, I hold power due to controlling the topic of research, direction of questionings, and consequent analyses. However, participants were qualified clinical psychologists, whilst I am a trainee and so in regards to relational dynamics increased power could be considered to lie with the participants. This may have enabled participants to feel safer in expressing their thoughts and views due to feeling safer in the knowledge that they had greater knowledge than the interviewer. Additionally, my role as a trainee clinical psychologist may also have afforded me 'inside status' (Given, 2008) due to myself being part of the same system being explored with participants. This may have facilitated participant openness due to unspoken assumptions that we position ourselves similarly with regards to psychotropic medication, and due to mutual understanding and knowledge about the research topic. In an attempt to remain neutral, I did not share any of my personal beliefs prior to interviews, however, a few participants asked me about my opinions afterwards. This possibly suggests inside status reflected in a desire to exchange views about a topic relevant to our professions.

5.4 Reflections on Analysis

The interviews were initially coded inductively prior to using the deductive framework. It is important to bear in mind, however, that due to the mixed method nature of the study I approached the transcription analysis with knowledge of data from the online survey. I was also wary of minimising bias, and personal beliefs leading me to focus on certain aspects of the data at the expense of others. This was particularly important given my background interest in critical literature on psychotropic medication; I did not want to become engrossed in participant's critical approaches and ignore other aspects and

roles. Being new to qualitative research, I found working with eleven transcriptions quite overwhelming and at times felt I was losing sight of my research aims, and struggling to really 'see' the data. I wrote in my reflective diary at this time to capture some of my anxieties: -

"I don't really feel immersed in my project at the moment and it feels more like a chore. I have begun coding the qualitative data and have research supervision to discuss this today. Given the diversity of things people have said, I'm finding it hard to remember and stick to my initial question looking at 'current involvement' and keep being swept away by people's opinions and potential roles for psychologists." (6th September 2017)

I used research supervision to discuss concerns, and found it helpful to have my research supervisors offer their insights. Themes were derived over several research supervisions, including input from an external supervisor in attempts to minimise bias and ensure themes made were coherent. Being new to qualitative research I found this process quite tiring and frustrating, the process taking much longer than I had anticipated. There were several times when I felt I finally had my themes, only to begin drafting and realise further refinement would be appropriate. Braun and Clarke (2013) acknowledge that researchers need to decide when they will stop refining themes, as this process can be ongoing. Analysis was concluded following external supervisory input, as all researchers were in agreement that the final conceptual thematic map was logical and represented the data.

5.5 Theoretical Reflections

An aspect of the research that proved both a positive and a challenge was the atheoretical nature of the topic area and research questions. This allowed for flexibility in considering the application of psychological theory to the phenomenon, however, I found this challenging due to its broad nature. Personally, I lean more towards constructivist ways of thinking about reality, focusing on individual experience rather than an existence of an objective truth. This is represented within my clinical practice, as I generally favour qualitative

feedback over quantitative measures, believing they can miss individual differences and lose sight of context. With this in mind, I appreciate that in order to organise and draw comparisons, the structure of such quantitative measures can be useful tools. This paradigm conflict presented difficulty in incorporating quantitative and qualitative components of the research, in understanding the epistemological position most appropriate to the research design, and my own way of thinking. I initially considered pragmatism due to its frequent association with mixed methods research, but upon further reading learnt of critical realism and felt this approach provided best fit. There is no denying of an objective reality, but accounts for researcher influence and participant's constructions of reality.

The following extract reflects some thoughts noted after interviewing a participant who identified as being a social constructionist, which are then related to epistemology and associated challenges: -

“Just did my 6th interview, was a really interesting one because she had quite strong ideas around use of medication and how she works in practice. She started off by saying that she considers herself as a social constructionist, and so totally disagrees with the use of medication to treat mental health problems. I thought it was interesting because when I think about the way she described working, I’m pretty sure my online survey and the options presented wouldn’t really have captured that. She took more of a passive aggressive kind of approach in relation to her involvement with medication, she would share critical articles and gain allies to get others on board with her way of thinking. It was more about making small changes here and there, and try to stop clients being referred to the psychiatrist instead of taking people off medication when it’s too late. This made me think about just how complex ‘involvement’ can be, which I didn’t really consider when I first started designing the study. It also reflects forms of ‘involvement’ I had never really considered before.” (25th August 2017)

By allowing participants to talk openly they were able to discuss factors they perceived as most important and allow insight into how they construed their reality. Sole use of the online survey, coming from a positivist approach would have assumed that predefined options represented reality of practice. I feel that the benefit of using mixed methods allowed for previously undefined forms of involvement to arise, resulting in unexpected findings and new ways of thinking about the topic than were conceptualised in the online survey.

5.6 Ethical Reflections

My initial thoughts in regards to reflecting on ethical issues, is that I don't feel my study encountered or raised any substantial ethical issues. I was mindful of time requirements made of participants, particularly as there was no incentive offered for taking part. As a trainee I am aware of the time pressures for clinical psychologists. Attempts were made to minimise demands by offering to travel to participant's work base, or conducting the interview over Skype or telephone. I also ensured that interviews did not overrun an hour's length, as specified in the participant information sheet.

I felt somewhat of an obligation to represent all of the interview participants and do justice to their contributions. Due to such a large volume of data and limited word space, decisions had to be made regarding which data to include and leave out. Attempts were made to justify decisions by use of an audit trail, however, I have invariably had influence over which data is presented. By using reflection and supervision I have aimed to incorporate all views, not just those I may align with, and have hoped to fairly represent all participants across both papers.

5.7 Reflections On Research Implications

A key implication resulting from the study is that professional guidance on working with psychotropic medication may help to inform clinical psychologists' practice. My initial reflections on the implications were that I worried they were somewhat vague, and also whether guidelines would in fact be helpful. This partly stemmed from the findings of Randall-James and Coles (2018) whereby clinical psychologists appeared to struggle to work beyond diagnosis, despite

professional guidelines being in place. This made me wonder the extent to which guidelines might impact practice or may remain largely uninfluential. However, on further reflection I considered how participants working in ID services felt an increased need to advocate on behalf of their clients, possibly backed by initiatives such as STOMP (Voluntary Organisations Disability Group, 2017). Whilst guidelines may not necessarily always be followed, this made me realise that having backing in terms of formal documents could serve to permit perceived authority to become involved. This may also help clarify some aspects of the weighing up process, and so I do think that guidelines could be useful.

I would also like to think that the findings will be interesting to many clinical psychologists and continue the debate around involvement with psychotropic medication. I think this is especially timely given that the BPS are moving towards considering prescription privileges. Whilst prescribing was not a key aspect within the current study, I think the findings are still interesting within this context and demonstrate the extent to which clinical psychologists can have influence with medication without prescription privileges.

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Appendices

Appendix A: Charles et al. (1997) Shared Decision Making Criteria.

- 1) Including the patient in the decision making process (for example, listening, finding out what the patient already knows, involving patients in the definition of the problem, ensuring that patients understand the clinical problem and the nature of the decision required).
- 2) Exploring patients' worries, fears and expectations (for example, discussing uncertainties, providing opportunities for questions, and setting goals).
- 3) Discussing potential treatment options (for example, agreeing levels of involvement in the decision making process - which may result in patients deciding they do not wish to be involved, discussing intervention options considering risks and benefits).
- 4) Providing information (for example, communicating risk, providing information about interventions, discussing pros and cons).
- 5) Ensuring information is understood (for example, discovering the level of a patients' understanding about a condition and the intervention options, obtaining patients' views about intervention).
- 6) Ensuring patients are happy with the decision making process and the decisions made (for example, encouraging patients to be involved in actioning intervention plans, asking patients' preferences).
- 7) Providing opportunities to review decisions made.

Appendix B: Online Survey

Firstly, create a unique code so that your responses can be identified should you wish to withdraw from the survey at a later date. Please use the first three letters of your maiden name and the two numbers of your birth date. For example, if your maiden name was 'Smith' and you were born on the 5th of the month your code would be: SMI05. Please make a note of this code.

Q1. What is your gender?

- ☐ Male
- ☐ Female

Q2. How many years have you been qualified?

- ☐ Less than 5
- ☐ 5-10
- ☐ 11-15
- ☐ 16-20
- ☐ 20+

Q3. Do you work in an inpatient or community service? (Please select both if applicable)

- ☐ Inpatient
- ☐ Community

Q4. Which type of service do you work in? (Please select more than one if applicable)

- ☐ Adult Mental Health
- ☐ Child and Adolescent
- ☐ Intellectual Disability
- ☐ Older Adult
- ☐ Physical Health
- ☐ Other

Q5. What is the dominant psychological approach you use within your practice?

- ☐ Cognitive
- ☐ Behavioural
- ☐ Cognitive-Behavioural
- ☐ Psychodynamic
- ☐ Systemic
- ☐ Other

Q6. Psychotropic medication refers to drugs capable of affecting the mind, emotions, and behaviour.

Have you completed any significant training relating to psychotropic

medication? If you answer 'Yes' please select approximately how many days training.

- ☐ Yes: Less than one day of training
- ☐ Yes: Between one day and one week of training
- ☐ Yes: More than one week of training
- ☐ No
- ☐ Unsure (please provide details)

Q7

Have you completed any significant training relating to psychotropic medication? If you answer 'Yes' please select approximately how many days training.

- ☐ Yes: Less than one day of training
- ☐ Yes: Between one day and one week of training
- ☐ Yes: More than one week of training
- ☐ No

If 'no' is selected – skips to What kinds of involvement have you had with psychotropic medication in the last six months? (Please tick all that apply)

Q8 Approximately how long has it been since you completed any significant training relating to psychotropic medication?

- ☐ Less than 5 years ago
- ☐ 5-10 years ago
- ☐ 11-15 years ago
- ☐ 16-20 years ago
- ☐ 20+ years ago

Q9 Which professional group did the trainer(s) belong to?

- ☐ Psychiatrists
- ☐ Pharmacists
- ☐ Psychologists
- ☐ Other _____

Q10. What kinds of involvement have you had with psychotropic medication in the last *six months*? (Please tick all that apply)

- ☐ None
- ☐ Referral to a psychiatrist/other prescriber for psychotropic medication

- ☐ Consulted with a psychiatrist/other prescriber about changing a service user's psychotropic medication
- ☐ Involved in the decision making process to prescribe a service user psychotropic medication
- ☐ Discussed psychotropic medication issues within individual service user sessions
- ☐ Discussed psychotropic medication issues in group therapy sessions
- ☐ Supplied information about psychotropic medication to a service user
- ☐ Requested or recommended that specific psychotropic medication be prescribed for a service user
- ☐ Requested or recommended that a service user be taken off a specific psychotropic medication
- ☐ Engaged in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication
- ☐ A psychological or neuropsychological assessment prompted recommendations for psychotropic medication
- ☐ Using psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects
- ☐ Reflecting with a service user on how their psychotropic medication may affect their engagement with psychology
- ☐ Reflecting with a service user on their general experience of taking psychotropic medication
- ☐ Taking the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)
- ☐ Supporting service users to discuss their psychotropic medication with their prescriber
- ☐ Other

Q11. Regardless of your current involvement, which of these options *would you do* given the opportunity? (Please tick all that apply)

- ☐ None
- ☐ Refer to a psychiatrist/other prescriber for psychotropic medication
- ☐ Consult with a psychiatrist/other prescriber about changing a service user's psychotropic medication
- ☐ Involvement in the decision making process to prescribe a service user psychotropic medication
- ☐ Discuss psychotropic medication issues within individual service user sessions
- ☐ Discuss psychotropic medication issues in group therapy sessions
- ☐ Supply information about psychotropic medication to a service user
- ☐ Request or recommend that specific psychotropic medication be prescribed for a service user
- ☐ Request or recommend that a service user be taken off a specific psychotropic medication
- ☐ Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication

- ☐ Recommend or request psychotropic medication prompted by a psychological or neuropsychological assessment
- ☐ Use psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects
- ☐ Reflect with a service user on how their psychotropic medication may affect their engagement with psychology
- ☐ Reflect with a service user on their general experience of taking psychotropic medication
- ☐ Take the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)
- ☐ Support service users to discuss their psychotropic medication with their prescriber
- ☐ Other

Q12. Are there any options that you feel are *inappropriate* for Clinical Psychologists to be engaging in? (Please tick all that apply)

- ☐ None - they are all appropriate
- ☐ Referral to a psychiatrist/other prescriber for psychotropic medication
- ☐ Consult with a psychiatrist/other prescriber about changing a service user's psychotropic medication
- ☐ Involvement in the decision making process to prescribe a service user psychotropic medication
- ☐ Discuss psychotropic medication issues within individual service user sessions
- ☐ Discuss psychotropic medication issues in group therapy sessions
- ☐ Supply information about psychotropic medication to a service user
- ☐ Request or recommend that specific psychotropic medication be prescribed for a service user
- ☐ Request or recommend that a service user be taken off a specific psychotropic medication
- ☐ Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication
- ☐ Recommend or request psychotropic medication prompted by a psychological or neuropsychological assessment
- ☐ Use psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects
- ☐ Reflect with a service user on how their psychotropic medication may affect their engagement with psychology
- ☐ Reflect with a service user on their general experience of taking psychotropic medication
- ☐ Take the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)
- ☐ Support service users to discuss their psychotropic medication with their prescriber

Q13. Which three forms of involvement do you consider the most important for Clinical Psychologists to be engaging in? (Please select three items, unless choosing option one)

- ☐ None - I don't think there should be any involvement
- ☐ Referral to a psychiatrist/other prescriber for psychotropic medication
- ☐ Consult with a psychiatrist/other prescriber about changing a service user's psychotropic medication
- ☐ Involvement in the decision making process to prescribe a service user psychotropic medication
- ☐ Discuss psychotropic medication issues within individual service user sessions
- ☐ Discuss psychotropic medication issues in group therapy sessions
- ☐ Supply information about psychotropic medication to a service user
- ☐ Request or recommend that specific psychotropic medication be prescribed for a service user
- ☐ Request or recommend that a service user be taken off a specific psychotropic medication
- ☐ Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication
- ☐ Recommend or request psychotropic medication prompted by a psychological or neuropsychological assessment
- ☐ Use psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects
- ☐ Reflect with a service user on how their psychotropic medication may affect their engagement with psychology
- ☐ Reflect with a service user on their general experience of taking psychotropic medication
- ☐ Take the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)
- ☐ Support service users to discuss their psychotropic medication with their prescriber

Q14. Would you say that you have strong views regarding the use of psychotropic medication?

- ☐ Yes
- ☐ No
- ☐ Undecided

Q15. Please elaborate on your views regarding the use of psychotropic medication

Q16. Do you consent to being contacted for a follow up interview? If you select 'Yes' please enter your email address. (Dependent on location this may be conducted via video conferencing)

☐ Yes

☐ No

Appendix C: Survey Advertisement

Do Clinical Psychologists have a role in clients' use of psychotropic medication? - DClinPsy Research Project.

Clinical Psychologist participants wanted.

I'm a second year trainee on the Trent doctorate and I am currently looking to recruit qualified Clinical Psychologists to complete an online survey as part of my DClinPsy research project. The survey may take approximately 20 minutes to complete.

We are interested in your views of and experience with involvement of client's psychotropic medication. I am hoping to recruit as many Clinical Psychologists as possible regardless of views and experience.

My project is a mixed method design and there is an option at the end of the survey to consent to being contacted for follow-up interviews. Not everybody who consents to this will necessarily be contacted.

If you have any comments or questions, please feel free to contact me on 15591138@students.lincoln.ac.uk

Please click the following link to open the survey:

<https://lincolnpsych.eu.qualtrics.com/SE/...>

Thank you for your time.

Appendix D: Survey Advertisement (Division of Clinical Psychology Forum)

Re: Joining the debate around psychiatric medication

IN RESPONSE to 'Joining the debate around psychiatric medication' (Philip Houghton, CPF286, October 2016) I am writing to reiterate the importance of this topic by introducing my thesis research project. I hope this will continue the debate proposed by Philip.

Do clinical psychologists have a role in clients' use of psychiatric medication?

I was interested to read Philip Houghton's article, 'Joining the debate around psychiatric medication', as my doctoral research project aims to explore clinical psychologists' involvement with clients' use of psychiatric medication. Psychologists and their involvement with psychiatric medication is currently an under-researched area; the limited amount of research in the field has primarily been conducted in the US, and focuses on opinions concerning whether psychologists should have prescription privileges. Whilst traditionally pharmacology is not viewed as an aspect of the psychologists' role, Philip's article highlights significant ethical questions around medication use and the potential role psychologists may adopt in exploring clients' relationships with medication.

By researching this topic it is anticipated that findings will provide new information into how clinical psychologists position themselves with regards to psychiatric medication use, and how decisions are made when there is potential to intervene within clinical practice. Given that there is currently no professional guidance for how clinical psychologists may involve themselves, it is anticipated that current involvement is based on personal opinion and judgement. By examining individual accounts of these experiences, it is hoped that this

can allow clinical psychologists to consider (and potentially reconsider) their position on where they sit in terms of involvement with psychiatric medication. Philip suggests within his article that publically voiced statements could be expanded to create a statement position on medication use similarly to that of diagnosis (Division of Clinical Psychology, 2013). By exploring the involvement that clinical psychologists are currently having, this provides a starting point in considering potential statement positions and determining any future roles that clinical psychology as a profession may have with medication.

I am hoping to recruit as many clinical psychologists as possible regardless of personal opinion and involvement with psychiatric medication. If you are interested in taking part in the study please contact me on the e-mail address provided below to which further details will be provided. The study is mixed methods: Phase 1 is an online survey, and Phase 2 will involve interviews with a small number of clinical psychologists who completed the online survey.

Amy Aston

Trainee Clinical Psychologist, Nottingham Trent University; Lincolnshire Partnership NHS Foundation Trust; 15591138@students.lincoln.ac.uk or msxana@nottingham.ac.uk

References

Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnosis: Time for a paradigm shift*. Retrieved 6 December 2016 from www.bps.org.uk/system/files/Public%20files/cat-1325.pdf

Appendix E: VandenBos and Williams (2000) Forms of Involvement with Psychotropic Medication

Options of Involvement with Medication

Psychiatric referral for medication

Intake evaluation prompted recommendation for medical evaluation

Consulted with physician about changing patient's medication

Involved in decision making to prescribe medication to patients

Extensively discussed medication issues in individual psychotherapy

Psychological or neuropsychological assessment prompted recommendation for medical evaluation

Consultant with a team that included a professional with prescriptive authority

Requested or recommended that physician prescribe specific medication for patient

Used psychological and neuropsychological tests to monitor and measure medication effects

Extensively discussed medication issues in group psychotherapy

Appendix F: Interview Schedule

<p>1. What are your views or feelings about the use of psychotropic medication? <i>Prompts/follow-up: Where views came from. Views changing over time. Has type of service affected views. *jot down examples if given*</i></p>	<p>Most popular last 6 months: reflecting with a service user on their general experience of taking psychotropic medication discussing psychotropic medication issues within individual service user sessions supporting service users to discuss their psychotropic medication with their prescriber</p> <p>Most popular ‘would do’: reflecting with a service user on their general experience of taking psychotropic medication supporting service users to discuss their psychotropic medication with their prescriber engaging in a collaborative discussion with a service user to support them in making a decision about their psychotropic</p> <p>3 most important options selected from survey: Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication support service users to discuss their psychotropic medication with their prescriber be involved in the decision making process to prescribe a service user psychotropic</p>
<p>2. Do you encounter many opportunities to involve yourself with clients’ psychotropic medication? <i>Prompts/follow-up: what opportunities? *look at involvement options from survey to prompt*. Does service type affect range of opportunity?</i></p>	
<p>Tell me about a time you had an opportunity to involve yourself with a client’s psychotropic medication. What happened? <i>Prompts/follow-up: What did you do? Different kinds of involvement/further examples. What prompted decision? What factors helped you decide whether or not to get involved?</i></p>	
<p>3. Have you had similar opportunities but made different decisions about involvement? <i>Prompts/follow-up: what affected decision making.</i></p>	
<p>4. How do you feel about the decisions you made now? <i>Prompts/follow-up: Involvement successful? Has anything gone wrong? Do you wish you had made a different decision? Would you do it again?</i></p>	

<p>5. Do you feel you've expressed a personal view to your clients in regards to their psychotropic medication? <i>Prompts/follow-up: feelings about whether this was right/wrong, would or wouldn't do this again</i></p>	<p>medication reflect with a service user on their general experience of taking psychotropic medication medication Inappropriate most frequently selected response was requesting or recommending that specific psychotropic medication be prescribed for a service user no options were inappropriate requesting or recommending that a service user be taken off a specific psychotropic medication</p>
<p>6. Do you think Clinical Psychologists should have training about psychotropic medication? <i>Prompts/follow-up: what would you hope this training would enable you to do? What would you like to know more about?</i></p>	
<p>7. Is there anything you might have done that you didn't due to lack of training? <i>Prompts/follow-up: knowledge, confidence</i></p>	
<p>8. Do you think you should have a role with psychotropic medication? <i>Prompts/follow-up: what would the role look like? Would this role look different to the one you may have now?</i></p>	

Appendix G: Transcription Confidentiality Agreement

Transcription Services - Section 7



Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of 07/07/17, by and between the University of Lincoln, with principal offices at Brayford Road Lincoln LN6 7TS (the University) and Helen Smith with principal offices at 21 Southfield Avenue, Syston, Leicester, LE7 2LL, (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by Amy Aston which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of Helen Smith

Signed: H. Smith Name:

Title: H.S.S. Date: 12/7/17

Signed for and on behalf of the University of Lincoln

Signed: Name:

Title: Date:

Appendix H: University Ethical Approval



15th February 2017

TO WHOM IT MAY CONCERN

This is to confirm that Amy Aston's ethical approval for PSY1617150 "*Do Clinical Psychologists have a role in clients' use of psychotropic medication? A mixed methods investigation exploring current forms of involvement*" was considered and approved by the committee of SOPREC

If you have any queries about the ethical approval, please email soprec@lincoln.ac.uk, alternatively call 01522 835510

Kind regards

A handwritten signature in black ink, appearing to read "Aidan", written in a cursive style.

Dr Aidan Hart
Chair of School of Psychology Research Ethics Sub Committee

pp: By Zoë Mead, Officer of Chair of School of Psychology Research Ethics Sub Committee

School of Psychology

College of Social Science University of Lincoln Brayford Pool Lincoln LN6 7TS United Kingdom
www.lincoln.ac.uk T +44 (0)1522 835510 soprec@lincoln.ac.uk

Appendix I: Participant Information Sheets

Online Survey.

Do Clinical Psychologists have a role in clients' use of psychotropic medication? A mixed methods investigation exploring current forms of involvement

Before you decide to participate it is important that you know what the study will involve. Please take the time to read the following information before deciding if you wish to participate.

My name is Amy Aston and I am a Trainee Clinical Psychologist studying at the University of Lincoln. I would like to invite you to take part in a research study looking at when and how Clinical Psychologists involve themselves with clients' use of psychotropic medication.

What is the purpose of the study?

Traditionally pharmacology is not viewed as an aspect of the Clinical Psychologist role. Research in the United States of America, however, suggests that psychologists may be more involved with use of psychotropic medication than previously thought. Little is known about this relationship in the United Kingdom (UK), therefore, this study aims to explore the relationship between Clinical Psychology and psychotropic medication in terms of questioning what involvement Clinical Psychologists are currently having, and potentially what role Clinical Psychologists could have.

It is anticipated that this study will provide new information into how Clinical Psychologists position themselves with regards to psychotropic medication use, and how decisions are made when there is potential to intervene within clinical practice. Given that there is currently no professional guidance for how Clinical Psychologists may involve themselves, it is anticipated that current involvement is based on personal opinion and judgement. By examining individual accounts of these experiences it is hoped that this can allow Clinical Psychologists to consider (and potentially reconsider) their position on where they sit in terms of involvement with psychotropic medication.

This research has two phases. Phase one is the survey, which you are currently being invited to take part in. There will be an option for you to express an interest in being contacted about involvement in the second phase. This research is being funded by the Trent Doctorate in Clinical Psychology (DClinPsy). The project is being completed as part of the DClinPsy qualification and is being supervised by:

Dr Sharron Smith
School of Psychology, College of Social Science
Senior Clinical Tutor
University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS
Email address: shsmith@lincoln.ac.uk

Dr Danielle De Boos
Academic and Research Tutor, Faculty of Medicine & Health Sciences
University of Nottingham, YANG Fujia, Jubilee Campus, Wollaton Road,
Nottingham, NG8 1BB
Email address: danielle.deboos@nottingham.ac.uk

Dr Anna Tickle
Academic Tutor, Faculty of Medicine & Health Sciences
University of Nottingham, YANG Fujia, Jubilee Campus, Wollaton Road,
Nottingham, NG8 1BB
Email address: anna.tickle@nottingham.ac.uk

What will I have to do?

You have been invited to take part in phase one

Phase one – online survey

You have been invited to take part in phase one which is an online survey. The survey has 15 questions and should take approximately 20 minutes to complete. There are yes/no, multiple choice and free text response questions. You will also be asked to provide descriptive information about yourself such as gender, the type of service in which you work, and years qualified as a Clinical Psychologist.

Phase two - interviews

It is planned that follow up interviews will be conducted with a small number of participants who take part in the online survey. The aim is to expand on the data collected within the online survey and gather further detail and personal experience. If you are happy to be contacted about participating in further interviews you can consent to this by ticking the option at the end of the survey and providing your email address. If you are contacted for a follow up interview a separate information sheet will be provided in order for you to decide whether you would like to take part.

Who is organising the research?

The research is being organised by the University of Lincoln.

Why have I been asked to take part?

You have been invited to take part in this study due to your qualification as a Clinical Psychologist, and because you are currently living and working in the UK. I am hoping to recruit as many Clinical Psychologists as possible within the National Health Service and private sector.

Is my taking part confidential?

This study will follow ethical and legal practice and all information about you will be handled in confidence. You will not be asked for personally identifiable information such as name or date of birth. If you consent to take part the data collected for the study will be looked at by the researchers listed below. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. Each response has its own unique code so that you

cannot be identified. All data will be kept strictly confidential and stored on a password protected database.

You will only be asked to provide an email address if you wish to express an interest in taking part in the second phase of this research project. If you chose to leave your email address, this will be kept for the duration of the project and deleted upon study completion. All other data will be kept securely for seven years. After this time your data will be disposed of securely.

Although your responses are confidential, should you disclose anything which is felt puts you or anyone else at any risk, it may be necessary to report this to the appropriate persons.

Do I have to take part?

Participation in this research is voluntary. If you do decide to take part you will be asked to give your consent by ticking a box on the following page. If you decide to take part you are still free to withdraw at any time and without giving a reason.

Should you change your mind about participating in the study later, you have two weeks in which to withdraw your data. If you decide that you wish to have your data withdrawn please contact the School of Psychology ethics committee on soprec@lincoln.ac.uk with your participant ID code and the name of the study. SOPREC will then arrange with the researcher for your data to be removed. No identifiable details will be forwarded to the researchers and your anonymity to the researcher will remain intact.

Are there any risks in taking part?

There are no known risks anticipated with this research study. Participants are reminded of the need to uphold confidentiality and as such do not provide any identifiable information about clients within their answers. Risks of an online security breach will be minimised by storing responses on an encrypted computer.

If you decide to take part you are still free to withdraw at any time and without giving a reason.

Are there any benefits in taking part?

We cannot promise the study will help you but the information we get from this study may help to establish a starting point for understanding the role Clinical Psychologists are currently having with psychotropic medication. This could have future implications for considering whether guidance and/or training could be amended.

What will happen to the results of the study?

This study will be written up as part of the Trent Doctorate in Clinical Psychology (Universities of Lincoln and Nottingham) requirements. It may also be published in relevant journals and/or presented at relevant conferences/events. You will not be identifiable in any way should the research be published. Information on time and location of publication will be distributed should you consent to receive this information.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: School of Psychology Research Ethics Committee, SOPREC, College of Social Science, University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS
E-mail address: soprec@lincoln.ac.uk

If you decide to participate in the research and experience any discomfort or wish to stop then you may withdraw at any time and without giving a reason. Should you change your mind about participating in the study later, you have two weeks in which to withdraw your data.

If you have any concerns about this study or what you have been asked to, then please contact the School of Psychology Research Ethics Committee on SOPREC@lincoln.ac.uk.

What if I have other questions or queries?

If you have any other questions or queries about the study then please feel free to ask the researcher on:

Amy Aston

Trainee Clinical Psychologist

University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS

Email address: 15591138@students.lincoln.ac.uk

The research supervisors' details can also be found below.

Research supervisors:

Dr Sharron Smith

School of Psychology, College of Social Science

Senior Clinical Tutor

University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS

Email address: shsmith@lincoln.ac.uk

Dr Danielle De Boos

Academic and Research Tutor, Faculty of Medicine & Health Sciences

University of Nottingham, YANG Fujia, Jubilee Campus, Wollaton Road,

Nottingham, NG8 1BB

Email address: danielle.deboos@nottingham.ac.uk

Dr Anna Tickle

Academic Tutor, Faculty of Medicine & Health Sciences

University of Nottingham, YANG Fujia, Jubilee Campus, Wollaton Road,

Nottingham, NG8 1BB

Email address: anna.tickle@nottingham.ac.uk

Appendix J: Participant Information Sheets

Interviews.

Interview Information Sheet

Title of Study: Do Clinical Psychologists have a role in clients' use of psychotropic medication? A mixed methods investigation exploring current forms of involvement

Name of Researcher(s): Amy Aston

I would like to invite you to take part in our research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. Please ask if you have any questions.

What is the purpose of the study?

This study aims to explore when and how Clinical Psychologists involve themselves with psychotropic medication. The majority of research into the relationship between psychology and medication has been conducted in the United States of America, however currently little is known about when and how Clinical Psychologists involve themselves with psychotropic medication in the UK. It is anticipated that Clinical Psychologists may frequently encounter opportunities to intervene within clinical practice, however currently little is known about how these decisions are made and the rationale for these decisions. It is hoped that this can allow Clinical Psychologists to consider (and potentially reconsider) their position on where they sit in terms of involvement with psychotropic medication.

This phase of the study hopes to gather more detailed information as to how decisions are made when there is potential to intervene in regards to psychotropic medication within clinical practice. It is hoped that this can allow Clinical Psychologists to consider (and potentially reconsider) their position on where they sit in terms of involvement with psychotropic medication.

Why have I been invited?

You have been invited to take part in this study due to having expressed an interest to participate in interviews after completing the online survey. I am hoping to recruit approximately 10-15 Clinical Psychologists to take part in the interviews.

Do I have to take part?

Participation in this research study is voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

Dependent on your location, the researcher may travel to you in order to conduct the interview. This may take place at your work base, dependent upon permission granted by the service manager. Alternatively, the interview may take place over video conferencing software if this is more convenient. You will take part in one semi-structured interview which will last approximately 60

minutes. You will be asked questions about your opinions and experiences relating to psychotropic medication within your clinical practice and the interview will be audio recorded.

What are the possible disadvantages and risks of taking part?

The interviews are anticipated to last for approximately 60 minutes therefore this amount of time is required to be set aside. Participants should be mindful of confidentiality when discussing professional experiences during interview and should not state client names or any identifiable information. Interviews will also be conducted within a secure environment to protect confidentiality. If being conducted via video conferencing the location of interviews will be agreed beforehand. The audio recording will be stored on an encrypted data stick to minimise risk of confidentiality breaches.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to establish a starting point for understanding the role Clinical Psychologists currently have in issues relating to psychotropic medication. This could have future implication for considering whether guidance and/or training could be amended and whether Clinical Psychology's' relationship with psychotropic medication should be reconsidered.

What happens when the research study stops?

If you wish to receive a summary of findings from the study and are happy to be contacted, you are able to leave details with the researcher who will contact you upon completion of the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting:

School of Psychology Research Ethics Committee

SOPREC

College of Social Science

University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS

E-mail address: soprec@lincoln.ac.uk

Will my taking part in the study be kept confidential?

This study will follow ethical and legal practice and all information about you will be handled in confidence. If you consent to take part, the data collected for the study will be looked at by authorised persons from the Universities of Lincoln and Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential. It will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it. It will

be password protected and stored on an encrypted data stick. Data will be kept securely for 7 years. After this time your data will be disposed of securely. Although your responses are confidential, should you disclose anything which is felt puts you or anyone else at any risk, it may be necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

This study will be written up as part of the Trent Doctorate in Clinical Psychology (Universities of Lincoln and Nottingham) requirements. It may also be published in relevant journals and/or presented at relevant conferences/events. You will not be identifiable in any way should the research be published. Information on time and location of publication will be distributed should you consent to receive this information.

Who is organising and funding the research?

This research is being organised by the University of Lincoln and is being funded by the Trent Doctorate in Clinical Psychology.

Who has reviewed the study?

This research has been reviewed and given favourable opinion by the University of Lincoln Ethics Committee.

Further information and contact details

Chief investigator:

Amy Aston
Trainee Clinical Psychologist
University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS
Email address: 15591138@students.lincoln.ac.uk

Research supervisors:

Dr Sharron Smith
School of Psychology, College of Social Science
Senior Clinical Tutor
University of Lincoln, Brayford Pool, Lincoln, Lincolnshire, LN6 7TS
Email address: shsmith@lincoln.ac.uk

Dr Danielle De Boos
Academic and Research Tutor, Faculty of Medicine & Health Sciences
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Appendix J: Consent Forms

Online survey.

Please tick each box to continue:

- ☐ I confirm that I am aged 18 or over and that I have read and understand the information above pertaining to this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- ☐ I understand that my participation is voluntary and I understand that I can withdraw my data at any point up until two weeks after completing the study.
- ☐ I understand that data will be kept confidential and securely and will be anonymised throughout.
- ☐ I understand if I have any questions or concerns, that I can contact the researcher supervisor using the contact details given.
- ☐ By proceeding with participation I am confirming that I wish to take part in this study and confirm that I agree to all the above statements.
- ☐ I confirm that I am a qualified Clinical Psychologist working in the United Kingdom and I am registered with the Health and Care Professions Council (HCPC). By clicking the NEXT button to begin the online questionnaire, I indicate my willingness to voluntarily take part in the study.

Appendix J: Consent Forms

Interviews.

Title of Study: Do Clinical Psychologists have a role in clients' use of psychotropic medication? A mixed methods investigation exploring current forms of involvement

Name of Researcher: Amy Aston

Name of Participant:

Please initial box

- | | | |
|----|---|--------------------------|
| 1. | I confirm that I have read and understand the information sheet version number 2 dated 20/06/16 for the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. | <input type="checkbox"/> |
| 3. | I understand that data collected in the study may be looked at by authorised individuals from the Universities of Lincoln and Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. | <input type="checkbox"/> |
| 4. | I agree that the information I have given and the information gathered about me can be stored by Amy Aston at the University of Lincoln, for possible use in future studies. Any samples or data used will be anonymised, and I will not be identified in anyway. | <input type="checkbox"/> |
| 5. | I agree to take part in the above study. | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix K: Debrief

Debrief

Thank you for taking part in this study.

This study was investigating when and how Clinical Psychologists involve themselves with psychotropic medication. It is anticipated that this study will provide new information into how Clinical Psychologists position themselves with regards to psychotropic medication use, and how decisions are made when there is potential to intervene within clinical practice. Given that there is currently no professional guidance for how Clinical Psychologists may involve themselves, it is anticipated that current involvement is based on personal opinion and judgement. By examining individual accounts of these experiences it is hoped that this can allow Clinical Psychologists to consider (and potentially reconsider) their position on where they sit in terms of involvement with psychotropic medication.

If you have any further questions about the study, please feel free to contact the researcher or their supervisor on:

Amy Aston (Researcher): 15591138@students.lincoln.ac.uk

Dr Sharron Smith (Primary supervisor): shsmith@lincoln.ac.uk

If you have any concerns about the ethics of this study or you wish to complain about the study or how you have been treated, then please contact the School of Psychology ethics committee on soprec@lincoln.ac.uk with details of your complaint and it will be investigated.

Should you change your mind about participating in the study later, you have two weeks in which to withdraw your data. If you decide that you wish to have your data withdrawn please contact the School of Psychology ethics committee on soprec@lincoln.ac.uk with your participant ID code and the name of the study.

SOPREC will then arrange with the researcher for your data to be removed. No identifiable details will be forwarded to the researchers and your anonymity to the researcher will remain intact.

Thank you again for taking the time to participate in our study.

Appendix L: Deductive Framework

Highest frequencies from survey	Involvement during last 6 months
	reflecting with a service user on their general experience of taking psychotropic medication
	discussing psychotropic medication issues within individual service user sessions
	supporting service users to discuss their psychotropic medication with their prescriber
	Would do if given the opportunity
	reflecting with a service user on their general experience of taking psychotropic medication
	supporting service users to discuss their psychotropic medication with their prescriber
	engaging in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication
	3 most important options
	Engage in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication
	support service users to discuss their psychotropic medication with their prescriber
	be involved in the decision making process to prescribe a service user psychotropic medication
	reflect with a service user on their general experience of taking psychotropic medication
	Involvement that is deemed inappropriate
	requesting or recommending that specific psychotropic medication be prescribed for a service user
	no options were inappropriate
	requesting or recommending that a service user be taken off a specific psychotropic medication
Other factors from survey	Participants working in CAMHS, ID, and Other were statistically more likely to have been involved in the decision making process to prescribe a service user psychotropic medication, compared with participants working in other services.
	Participants working in ID services were also statistically more likely to have requested or recommended that a service user be taken off psychotropic medication.
	Participants working in 'Other' services were statistically more likely to have used psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects.
Themes from qual survey data	Role of medication in care
	Medication "has a place"
	Medication has an important role in treatment.
	Medication is given priority over psychological approaches
	Medication might both help or hinder engagement with therapy
	Concerns about the use of psychotropic medication

	Used as a first line treatment						
	Long term use						
	Inappropriate use						
	Concern about side effects						
	Risks of medication are underplayed						
	Service user choice and consent						
	Lack of informed choice						
	Medication and coercion						
	Inaccurate depiction of medication						
	Collaboration in decision making about medication important						
	Client facing a power imbalance						
	Client's opinion isn't heard						
	Effectiveness of psychotropic medication as an intervention						
	False sense of hope						
	Not addressing underlying needs						
	Client and their difficulties not being understood						
	Difficulties unresolved						
	Not person centred						
	Role of the Clinical Psychologist						
	Medication is part of the clinical psychologist role						
	Knowledge about medication is required for role						
	Limited knowledge acting as a barrier to involvement						
	<table> <tr> <td>Inappropriate to the role</td><td> <ol style="list-style-type: none"> 1. prescribing 2. preventing use 3. recommendations 4. giving detailed information 5. discussions about medication </td></tr> <tr> <td>Part of the role</td><td> <ol style="list-style-type: none"> 1. discussing with client and team 2. giving general information 3. help inform decision making 4. supporting client 5. supporting medication reduction 6. offering psychological perspective 7. critical questioning role 8. offering a reflective space 9. monitoring effects of medication </td></tr> <tr> <td>Wishes for the role</td><td> <ol style="list-style-type: none"> 1. prescribing 2. increasing psychology and psychiatry collaboration </td></tr> </table>	Inappropriate to the role	<ol style="list-style-type: none"> 1. prescribing 2. preventing use 3. recommendations 4. giving detailed information 5. discussions about medication 	Part of the role	<ol style="list-style-type: none"> 1. discussing with client and team 2. giving general information 3. help inform decision making 4. supporting client 5. supporting medication reduction 6. offering psychological perspective 7. critical questioning role 8. offering a reflective space 9. monitoring effects of medication 	Wishes for the role	<ol style="list-style-type: none"> 1. prescribing 2. increasing psychology and psychiatry collaboration
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Wishes for the role	<ol style="list-style-type: none"> 1. prescribing 2. increasing psychology and psychiatry collaboration 						
	Need to work within professional boundaries						
	Signposting when area of out remit						
	Stance towards medication						
	Need to adopt open-minded and neutral stance towards medication						
	Adopting balanced perspective – disagree with use except in certain circumstances						
	Strong views - against medication						
	Medication use – at odds with how psychologists understand distress						
	Views changing						
	Critical view of evidence base						
	Wider service issues						
	Psychology minimized						
	Working alongside colleagues						

	Challenges with colleagues (in relation to medication)
	Dominant mental health paradigm
	Medication perpetuates dominant biological understanding of mental health difficulties
	Widely held belief that pills fix problems

Appendix M: Qualitative Survey Data: Example of Coding

<p>Decisions about should be: 1. Evidence based. 2. Person centred. 3. Last resort. Decisions in my experience are often: 1. Non-evidenced based or service users mislead on effectiveness. 2. Service users are given medication under compulsion which happens in no other area of medicine and in my mind hard to justify given the effectiveness data. 3. Service users are offered medication as a first line without any attempt to understand their distress as being an ordinary part of being human.</p>	<p>Criteria for decisions.</p> <p>Decisions not evidence-based. SUs mislead in effectiveness. SUs given medication under compulsion.</p> <p>Practice is hard to justify.</p> <p>Meds = first line attempt.</p> <p>No attempts to understand SU distress.</p>
<p>Within the service I work, which is for males with very high risk offending behaviours and severe and enduring MI, medication is a first line intervention. However I do have lots of input into the decision making process via the MDT which involves a consultant psychiatrist and senior clinical</p>	<p>Meds = first line intervention.</p> <p>Lots of input into MDT decision making.</p> <p>Medication expertise in team.</p>

<p>pharmacist, Because of the expertise around medication in my team, discussion psychotropic meds is not appropriate in my role, however we do discuss the psychological impact such as dealing with side effects and offer a psychological perspective to noncompliance with meds for example.</p>	<p>Discussion of meds inappropriate to role.</p> <p>Discuss psychological impact of meds.</p> <p>Offer psychological perspective to noncompliance.</p>
<p>I think they are too heavily and readily relied upon and not always appropriate. They certainly have their place however I think reliance on medication for difficulties such as emotionally unstable personality disorders is false economy. The investment needs to be in the evidence base such as DBT resources. There is no substantial evidence base for meds in EUPD and yet our dbt resource remains underfunded. Medications are too readily prescribed with no appreciation from the prescriber of the side effects- namely weight gain and the body image difficulties/ depression this can trigger. Readily prescribing medications perpetuates the notion of mental health as an 'illness' within the person and does not address the contextual factors. It also leads clients to believe their only hope of feeling 'better' comes from taking medication and that psychological approaches 'will</p>	<p>Too heavily and readily relied on. Not always appropriate. Meds have their place.</p> <p>Reliance for EUPD is false economy.</p> <p>Investment should be in therapeutic resources (rather than meds?).</p> <p>Meds used despite lack of evidence base. Too readily prescribed.</p> <p>Prescriber doesn't consider side effects.</p> <p>Perpetuates mental health as an</p>

<p>not work' because it doesn't remove the affect like medication does. It's a false recovery in my opinion- the source of the issue often remain unresolved and so begins a lifetime of medication to numb the affect. An expensive and not always appropriate system.</p>	<p>'illness'. Doesn't address contextual factors.</p> <p>Message of medication as only hope. Message that psychological approaches won't work like meds can.</p> <p>False recovery. Source of issue unresolved. Not always appropriate. expensive</p>
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Appendix N: Spreadsheet Tracking Interview Progress

CODE	Service/involvement	Email	Outcome	Replaced with:
	CAMHS high		bounced back	DONE - PARTICIPANT 5
			replace?	
	CAMHS low	emailed	DONE - PARTICIPANT 8	
	Adult low	emailed	DONE - PARTICIPANT 1	
	Older adult low	emailed	DONE - PARTICIPANT 11	
	Older adult high	emailed	EXCLUDED	
	Physical low	emailed	CANCELED	
	Physical high	emailed	EXCLUDED	
	ID low	emailed	EXCLUDED	DONE - PARTICIPANT 6
			DONE - PARTICIPANT 2	
	ID high	emailed	DONE - PARTICIPANT 3	
	Physical low	emailed		
	Adult high	emailed	EXCLUDED	DONE - PARTICIPANT 7
			DONE - PARTICIPANT 4	
	CAMHS high	emailed		
	Other neuro high	emailed	EXCLUDED	DONE - PARTICIPANT 10
			DONE - PARTICIPANT 9	
	Other forensic low	emailed		

Appendix O: Table of Interview Participants

Participant number	Service	Involvement
1	Adult	Low
2	ID	High
3	Physical	Low
4	CAMHS	High
5	CAMHS	High
6	ID	Low
7	Adult	High
8	Other – Eating disorder	Low
9	Other – Forensic	Low
10	ID	High
11	Older adult	Low

Appendix P: Summaries of Interview Participants

1 – works in acute and is generally pro-medication. Views have changed since working in acute and being shocked by how distressed, chaotic, and psychotic people can be. They have seen medication used in the first instance to reduce chaos and distress, and this has opened their eyes to the usefulness of it. If someone wasn't on any medication they are likely to prompt why this is, although the team are hot on this so it is unlikely this happens. Similarly, the team are good at not using medication when it isn't needed, so they are often relieved of having to question medication choices. Being in a very medical environment, it can feel uncomfortable and difficult to speak about medication or challenge its use. In these instances, it is felt that justification is needed e.g. referring to the evidence base, or the client in question is seen as having more of a psychological issue (e.g. PD) and so the psychologist has more authority to be talking about it. There also seems to be ideas about who the psychologist is 'allowed' to work with – this seems to be clients who are seen as having more psychological issues, rather than those viewed to be treated with medication. Also, a lot of thought and planning would go into things before actually saying something about medication or challenging, in order to look competent around professionals who are very medically minded. There is a sense of when working with people who are in such high states of distress you need to 'throw at it what you can' and see what works. There was also a tendency to view antipsychotics as more helpful than other medications such as antidepressants.

2 – works in LD service. Thinks there are particular difficulties for LD services because of the influence from external people. Providers or carers might come in and request something specific for a client, assuming they may not be able to advocate their own needs and have capacity, when in fact they do and might not want to take medication. Aware of critical narratives towards meds from psychology colleagues during training and is careful not to adopt this. Stance towards meds has softened over time and think there is a value in them. Meds can also offer choice and form part of a wider treatment package. Works in a service where they feel very fortunate to have psychologically minded psychiatrists who actively seek out advice from psychology before prescribing. There seems to be a tendency for psychiatry to feel like they need to prescribe

because they don't know what else to do, and psychology seem to have the power of saying 'no hold on a minute'. Psychiatry seem grateful for psychology's input. Awareness of medication seems to be important in order to map behaviour outcomes [what is effective? Therapy or medication?]. Feel a duty of care to be honest about meds and that they aren't likely to be the only answer. Information about med changes seems particularly important in an LD service due to the need to map any behavioural changes and because the client may not be able to articulate this for themselves. Even more need to have care teams on board and let them know that you need to be informed of any changes. Feel that it is a particular experience working in LD that there is increased involvement with medication due to the crossover with behavioural work and the need to advocate on behalf of the client.

3 – works in a specialist cancer service in a team solely of psychologists. Thinking about a continuum, would place themselves on the 'pro-medication' side of this. This is based on both personal and professional experience – they have previously taken psychotropic medication and they are about to marry a psychiatrist. Don't tend to prompt discussions about meds with clients because there is an added complexity of alternative drugs people are taking for cancer and don't feel they know enough about this. As the service is a medical service there is also some thoughts around the clients usually going to see a doctor with a medical problem and being fixed, and they perceive the therapist relationship to be different and don't want to promote an expert stance in a similar way. Experienced clinical training to be very critical of psychiatry and medication and disagreed with this. It also felt like training tried to encourage psychologists to take an advocacy role in promoting formulation and moving away from diagnosis and medication use. However, in real practice this did not seem feasible. Having a psychiatrist for a fiancé and previously having taken antidepressants in the past have led to previous views being challenged. This is due to having increased insight into how psychiatry training is delivered and experiencing positive effects of taking psychotropic medication. Feel that overall taking a critical stance is unhelpful and psychologists should offer a balanced view to support clients in making an informed decision about their medication. Would see opportunities to promote this way of thinking as part of role.

4 - works in LD services. Considers self quite anti-medication personally and this shapes professional views. Doesn't really see views as changing over time, in fact, they have been strengthened by having colleagues and a supervisor who hold equally strong views and this has encouraged permission that it is OK to hold these views. Has experience of medication being used previously in adult mental health to support engagement with therapy, and even then was uncomfortable with the referral due to a worry about reliance on medication. Talks about 'layers' of involvement and will sometimes take a direct approach or a more gentle one depending on relationship with the prescriber and the context. A direct approach might be taken in a ward round to challenge a prescribing decision and outright say that they disagree with the decision. In order to feel confident in doing this they would have knowledge prepared beforehand in order to quote papers etc. in relation to the evidence base. This approach has worked well in the past, whereas at times taking a gentle approach means you can be overlooked. However, this approach can sometimes be appropriate outside of meetings in terms of being more suggestive 'let's try this first?'. Other layers of approaches include offering a wide complex formulation and thinking about challenging labels, and how services can develop to offer interventions beyond medication. There is a sense of not wanting to be responsible for medication decisions due to limited knowledge, but a role in contributing to help another make that decision. If a formulation has been presented, and the professional remit has been filled, then they feel OK that they have done all they can even if they disagree with the decision made. In order to try and influence the nursing staff they would hold a presence on the ward and drip-in formulations to promote that psychology has a role with challenging behaviour, as previously the staff did not see the function of psychology in this area. They say early on in the interview that they have found a direct approach is quite successful in getting people to listen, but later on say that they worry that this might come across wrong and get peoples back up so they are more recently trying to adopt more of a curious stance.

5 – works in CAMHS. Thinks there are particular issues when working in CAMHS such as containing parental anxiety when parents want medication for

their child if they are in a state of crisis. Within the team there are differences in the psychiatrists as in some may be more open to listening to psychological input than others, this might be down to when they trained. If the person seems to be struggling to engage in therapy then they might suggest talking to the psychiatrist, but would suggest this as an option and not influence any decision. A disclaimer would be given about knowledge. And actually, any improvement at engaging in therapy isn't seen that often. They may also possibly suggest medication as an option if the person has already had rounds of therapy and it doesn't seem to have helped – might be a case of seeing what else can be used/desperation at trying something else. They seem to have figured out people and situations whereby they can raise a query without negative experiences and this would be raised in a tentative way. there seems to be a sense of anticipating that it would not go well if raised with certain people due to not having appropriate authority and knowledge to do so. They admit that they don't take a confrontational approach, but rather use a tentative questioning approach. This is because they don't want to create rifts in the team. I'm getting a sense of them being scared to confront medical decisions, and will tentatively do it sometimes, and then the medics will say we're going to just trial it. Then they say oh yes it's good to trial things sometimes, but there is no mention of what happens when this trial stops. I think they seem to be happy that they questioned it and feel that being told it's a trial means it's OK and they won't have to question it again because they've been reassured it's only a trial. They feel fairly confident in their knowledge about medication and probably could have more conversations about it than they do, but worry about being blamed or giving bad advice and as such don't go out of their boundaries. Don't feel like they want to prescribe and reflect that actually when they do prompt a medication referral it's often out of desperation and they don't really believe it will help. They liked medication use to diagnosis, and neither fit with how they come to understand clients' difficulties.

6 – identifies as being a social constructionist and medication propels the idea of a disease model of mental distress. Found that in the early stages of career it was about finding a place in the team and not being too vocal about things. Now that they're leaving their role it feels a bit easier to talk up more and think about

the legacy they want to leave. Feels it's too difficult to influence change in the clinic room and does own reading/gathers professional allies in order to influence change from the ground up. This includes adopting a position that is not anti-meds but is social constructionist, as when you think about problems in this way it automatically gets rid of the need for medication use. This is done by information sharing and sending around critical articles to other people. There are times when they try to challenge decisions in the clinic room, which is done using a bit of a playful questioning approach, but they describe having to pick their battles as this can't be generalised. Also they know that if they weren't in the room then nothing would change, and so it is a more effective approach to stop people getting through the clinic door in the first place. As part of the tentative drip-feed approach one method is by providing alternatives to diagnosis as a means to preventing medication use. There are certain factors that influence whether they may decide to challenge a decision or not. This includes the mood of the psychiatrist and what they can get away with, how confident they feel that the case can be managed without it, and whether there is risk. They admit that if there is risk then this becomes difficult to challenge, due to agreeing that medication may help manage behaviour in the short term. If the idea of ADHD is challenged, then there is no more need to take medication anymore. They read a lot and follow people who publically voice critical views, and then pass these on to work colleagues themselves. They said its helpful when credible professionals stick their head above the parapet. Generally sees role as being an influencer and changing narratives and discourses. This is in line with their values and part of the legacy they want to leave when they finish their role. It is not enough just to be critical – need to raise awareness and also create action of providing alternatives.

7 – starts off by saying they have mixed views. They trained at a course that is known for having quite an anti-psychiatry stance. They have experienced services that welcome alternative opinions and this has increased their confidence in adopting a curious and questioning role. The most obvious reason they would chose to be involved with medication is when the formulation points to a problematic relationship with medication for a client, so a reliance on it or the use masking something. In this instance they might prompt a reduction or

question the necessity of med use themselves. They may also explore client beliefs about medication if it appears that the client is misinformed about medication and diagnosis. Usually they might question why a client has been on medication for so long, prompting people to think about the current clinical need as they might have been on it for years without anyone questioning this. This is usually where their role ends – they raise the idea but then may leave this with the client. On occasion though they report arranging a joint appointment with the client and the psychiatrist so that they can ask the psychiatrist questions in front of the client – this is to act as an advocate because the client may not be able to ask themselves (power dynamics) or may not think to. Also it's to make sure that the client is getting the same answer that the psychiatrist would give the staff. Having said all this, they feel that ultimately they make little change, and usually take more of a tentative approach over all. Similar to another participant, they have experience of the psychologist being the gateway person to challenge. They have found that colleagues may hold similar opinions but might not know the research or have the words to back it up. Once they have seen that this kind of thing can be challenged then they are more likely to do so without psychology's presence there. They see that they were trained to take on a role of challenging the status quo, however, feel that newer psychologists are seeing themselves more as only therapists and so don't feel empowered to do this. This means that the 'psychologist' position could be lost if we don't continue to fulfil these roles.

8 – generic mixed views – over used but think it can be helpful in certain situations such as helping people to engage with therapy. Works in eating disorder service and feels there can be more need for medication in specialised services such as this one. They are present in meetings when medication is discussed but don't comment on it due to a lack of knowledge. They say that they will offer 'alternatives' to medication, but it actually seems like they offer additional ideas on top of the medication rather than suggesting something else in its place. Working in eating disorder services, often when the client isn't in a place to engage in therapy they want to look at nutrition etc. first to help them feel better in terms of energy. It seems like they generally take a step back from medication related issues, and would only comment specifically if they are

confident and definite in their opinion – e.g. client is doing really well and doesn't need to be on medication. They feel that the team are quite good at reducing medication anyway, due to the added physical risks of people with low body weight being on medication. They suggest that they might raise it if they felt someone was on too much medication, but that usually they don't have to because the team are so good at it. I get the sense that this feels like a bit of a relief and they are glad that they don't have to raise issues very often. They use an example of talking to the GP about a client's medication when they express suicidal ideation and suggest taking an overdose. They say at the end when asked if they have anything else to add that they would generally consider themselves to err on the side of caution with medication rather than encouraging people to go to the GP, however, throughout the interview they suggested that they preferred to take a backseat and not really have much of a role.

9 – starts off by saying they think it's overused, people get stuck on them, it's medicalised and a paternalistic way of managing distress – mainly negative. Then go on to say on the other hand sometimes it's appropriate, like they don't want to be seem to be fully against. Works in a service for men who have just come out of prison, there are no psychiatrists directly involved. This has lead them to think about a more holistic approach as there is space to do so given the lack of medicalised environment. There is a psychiatrist who visits monthly to offer advice, but they take a passive role and don't dominate their working model. When newly qualified they worked in secure settings and found it sad that many patients were on medication, but were overweight and still experiencing psychosis. They did not feel that they had the confidence at the time to challenge and question the use of medication like they would now. They are big in offering client choice so to help people realise that they have a choice about being on medication as often clients can be taking medication for years and be stuck in a way of being. They also consider themselves to have a role in containing staff anxieties about clients coming off medication, as there seems to be an idea of panic that a client will become really risky if this happens. In terms of expressing personal opinions they said they will offer these, but then actually said they will give a pretty much balanced view 'has a place, can be helpful for

some but also harmful' so not sure if they do actually really give their personal views. They gave an example of working with a client who idealised medication as a way to cope and would constantly request changes, which would 'work' for a bit but then they'd want it changed again. They formulated this and showed it to the CMHT, who agreed and put a plan in place not to keep changing medication, but eventually the client started using other substances so its effectiveness was limited. They seem to have adopted a bit of a role of filling in the gaps that other professionals miss – so if the GP hasn't supplied information about medication then they will look into this because they feel they have a duty of care to the client and also they like to be helpful. This might be because there is no psychiatrist working in the service and as such the clients miss out on advice in the same way they might do if there was a psychiatrist.

10 – generally seems to be quite anti-medication. Clinical training was quite anti-diagnosis, and they acknowledge difficulties with being anti-diagnosis but being pro-medication and how those stances fit together. Despite having quite a critical stance during training they found that this didn't quite gear them up to working in medically dominated services. They were trained to be quite curious but found this doesn't actually work and you need to be more assertive. They think that they were already starting to take quite a critical stance on things prior to training and therefore training didn't really influence them to do this post-training. Part of their personality is being quite assertive which they think helps others to take them seriously. They find that if you come across as quite assertive this helps people take you seriously – psychologists are often encouraged to be quite tentative and curious, but they feel this leads to you being dismissed. They think about what influences them picking their battles. They would be more likely to challenge something if there is a suggestion of medication and it doesn't really fit with what they know about the person. They would be less like to challenge if they don't have an alternative to give, or it feels like everything else has already been tried. They said previously that you need to use quite an assertive direct approach in order to influence any change, but later on said it can be difficult to influence the psychiatrist because of the fear of dismissing their training and career. This might also be bad for building colleague relationships. To manage this they use a 'drip' approach – however,

this contrasts what they said earlier about tentative approaches not really working. They also talk about how it can be difficult to strike a balance of ensuring that clients are informed about medication but not forcing views. They use an example of a client taking clozapine which helps reduce voices, and the client felt that this had solved their problems. The psychologist, however, felt that it was only masking problems and wondered how sustainable it was – especially given using the drug for long term and the sacrifices this takes. Having said that, if the client wanted to mask the issues and not address the trauma this is their choice and it isn't the psychologists place to say. They suggest that they will still express their opinion and do it in a way that offers a formulation, this contrasts the medics approach of saying 'you have a disease and need this medication'.

11 – views were shaped by mum taking antidepressants and not having support to reduce these, and also seeing/hearing others saying they don't want medication but not having much choice. They now work in older adults in a care home which has a stepped care model. It is psychologically led, and the psychiatrist visits once a week. This means that clients don't see a psychiatrist as routine and it's down to the team to decide when to refer for a medication assessment. They work as part of an MDT and other clinicians might bring up the idea of medication but its ultimately down to the psychologist as care co-ordinator to have the final say on whether to put in the referral or not for medication. They need to have a fair bit of knowledge because they don't to be referring everything inappropriately. They say that they act as a bit of a middleman between clients families and the psychiatrist so it's helpful to have some knowledge because they can tell a client that what they're experiencing sounds like a side effect, or save the family having a conversation with the psychiatrist themselves. If they think a client is on too many medications or on appropriate medications they might refer for a med assessment. They said that their role is different to when they worked in adult inpatient settings – there they would take more of a questioning stance as to why clients were on medications, but do so less in older adult. They suggest that there might not be a role to reduce as much medication as possible because then it's creating extra work when there might not be any problems. For example, if a client is on a low dose

you could say what's the point in them taking it? But then working to reduce it when there's no problems is creating extra work when staff are already stretched.

Appendix Q: Coding: Initial Thoughts and Ideas

“One of the inappropriate options were requesting or recommending that a service user be taken off a medication, but it comes up quite often in interviews to challenge and argue for no medication. Maybe it feels more acceptable to challenge medication use before it’s prescribed rather than challenge it once someone is already taking it.”

“My main reflections from the deductive framework is that there are some forms of involvement that were considered inappropriate but actually people in the interviews told me that they do this. A lot of the other themes came up and were supported. Also, in interviews not that many people actually did some of the forms of involvement that were most selected in the survey. There are extra options that came up in the interviews that weren’t options in the survey, e.g. liaising with psychiatry without the client? “

“There seems to be a bit of a process going on. Participants are considering whether they want to become involved and then something seems to tip this into action and pushes them to do it. There also seems to be a bit of hesitancy for some people. I think this is part of people navigating their boundaries which seem quite hard to define.”

“A common concept seems to be struggling to put ideas into practice that are encouraged during training. People seem to think they have to go out and start challenging medicalisation, but then find this difficult in practice. Some people seem to have strong opinions and find this easier to do than others.”

“There seem to be many layers to involvement. I tried to do a bit of a circular diagram to capture these layers but it feels so complex to incorporate everything in. There is a level of being very directly involved, then more indirectly and working with staff, then moving to the outside whereby there is involvement but it is more in the form of querying or doing things on the peripheral. These layers feel integral to the analysis but at this stage I’m a little unsure on how to bring them all together.”

Appendix R: Interview Data: Example of Coding

<p>Q: Yes. Have you ever kind of had a role or been involved somehow but then kind of looked back and thought, maybe I shouldn't have done that or maybe I wouldn't do that if I could do that over?</p> <p>A: Yes, I suppose, yes, just thinking, it's, maybe sometimes with that, like it's a blessing in some ways that somebody is tasking you with something and they feel really, they trust that you can go and do that competently. But then, yes, on the flip side you think, should I be doing that? Should I be delving into asking a client about their medication because does that confuse the issue for them? So yes, often, in hindsight, you'll still reflect on, is that the best approach, is there other approaches? Was that just the easy option for that person and you'll, you know, I'll be quick to say, yes, that's fine, I'll do that. But actually, does that help my role with that client?</p> <p>If they've got issues around medication, I become associated with medication or become more associated with psychiatry when they're not engaging with psychiatry. Then am I, you know, am I going to be seen as aligned to, you know, that profession, in a kind of a, not that I'm advocating for medication, I'm asking them about it, but just the nature of having conversations with them about it on behalf of the psychiatry team. That, you know, sometimes, in hindsight, you think, well should I have said no? But sometimes you don't want to, you don't want to be seen to be unhelpful.</p>	<p>Being asked to work outside of role – seen as trusted and competent Factors influencing parameters – feeling trusted</p> <p>Reflecting on whether correct decisions made about intermediary role</p> <p>Increased role – client has issues with meds Increased role – client not engaging with psychiatry</p> <p>Concerns – perceived as aligned to psychiatry and advocating meds Concerns – being seen as unhelpful</p>
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<p>So yes, and maybe, I don't know, maybe in the past, I was thinking about whether I've been less involved with it because of thinking it's not my area. And actually, you know, being more aware and more knowledgeable. And sometimes I probably think to myself, I should be more knowledgeable about medication treatments, but then on the flip side, do I need to be? Because I'm not an expert in that and that isn't my professional, you know, my subscription and my professional identity. And my knowledge base isn't about medication, even though we do have a duty to understand, you know, the potential impact on a client.</p> <p>So that is, it's quite a big grey area generally, for psychiatry, isn't it, in psychology, sorry, in our profession in the UK. That we aren't prescribers but we do clearly, have a lot of cross over, in terms of thinking about medication, talking about medication and the impact on a client. But I'd certainly, know where I stand personally, is that it's not something that I would ever seek to be wanting in my profession, to be a prescriber. Because I just think it's too contraindicating with the ethos of our profession and what we're trying to do, is we're an alternative to psychiatry, we've come out of psychiatry alongside it, aligned, if we're trying to do that as well, where do our, what's the difference? And I think in other countries, you know, thinking like the US, you can prescribe as a psychologist. So you think, well what's the difference? That muddies, I think, really muddies the waters.</p>	<p>Level of involvement changed over time – historically not my area Internal battle – should I be knowledgeable vs. not my area Internal battle – med knowledge doesn't fit with professional identity Duty of care – understanding med impacts on client</p> <p>Grey area in profession – clear cross over into role</p> <p>Psychology prescribing - clear on no role</p> <p>Psychology prescribing – at odds with professional ethos</p> <p>Psychology prescribing – too similar to psychiatry</p>
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<p>So I think, I think I know where I stand with medication. I am still mindful that sometimes there is that critique. And I think that comes from my own personal standpoint on medication and how I seek out every other available option. And I don't necessarily want medication for things, I want other options. And, unfortunately, society's still quite, dragging its heels on that. The medical profession has been so powerful for such a long time that your GP doesn't give you a lot of other options other than prescriptions, when you go to talk to your GP about a problem. And that may not be what you need as a starting point to help you move forward with something, physical and, or, you know, mental health ailments.</p>	<p>Professional parameters & views – influenced by personal standpoint</p> <p>Medical profession powerful – prescribing first line treatment</p>
<p>So yes, I think it also, it's part of my own personal thoughts and attitudes. And I do have to be mindful about that, I suppose, when I talk to clients, about not being too dismissive of medication as an option. Because I know deep down I am very critical of the use of psychotropic medication and research trials and how ineffective it actually is, from my own personal opinion, from the research trials and drugs trials that you see. You know, it's a very small effect size a lot of the time and these drugs are getting mass produced as if they're really effectual and they're not. So I think sometimes the public are very misled with being very optimistic that their tablet or a, you know, particular medication or cream will remove a problem and treat the cause, and a lot of the time it doesn't.</p>	<p>Professional parameters & views – influenced by personal standpoint</p> <p>Holding back personal critical opinions from clients</p> <p>Critical personal opinion – misleading drug trials</p> <p>Public misled about effectiveness of meds</p>

<p>Q: Yes. It sounds like you think too much involvement would kind of, I suppose, blur the professional identity of psychology?</p> <p>A: Yes. Yes, and I think you do have to put your foot down sometimes. As I said, it's about finding that balance. So you're being helpful but then being quite clear about, no, that's where my role ends and I'm not going to get too more embroiled. You know, it's a surface level acknowledgement of, you know, there are other treatments available. And it's the same with other, MDT involvement, around functional assessments with OT or communication assessments with speech and language. There's often a crossover, roles aren't totally distinct, but it's knowing where you think, right this needs that specialism, rather than us, or this needs more them than us. And it's navigating those kind of subjective boundaries at times, about where our role ends and where we need someone else to pick up, and where we work together in that crossover, and that's not an exact science.</p> <p>But yes, certainly, getting too involved just becomes, we're too aligned to psychiatry, and we get that misconception a lot. So we need to make sure we're not kind of contributing to it too much at times, that we are a psychiatrist.</p>	<p>Need to make strict role boundaries clear to others Role in advocating other treatment options</p> <p>General overlap of MDT roles – distinguishing niche areas</p> <p>MDT working – navigating discipline boundaries and overlaps</p> <p>Confusion with psychiatry – care not to add to misperception</p>
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Appendix S: Research Supervision Log Example



**Trent Doctorate in Clinical
Psychology**



UNITED KINGDOM • CHINA • MALAYSIA

RECORD OF FORMAL SUPERVISORY MEETING

Name: Amy

Aston

Intake:

1516

Title of project: Do Clinical Psychologists Have a Role in Clients' Use of Psychotropic Medication? A Mixed Methods Investigation Exploring Current Forms of Involvement

Primary supervisor: Sharron Smith

Second supervisor: Danielle De Boos

Field supervisor:

Supervision No.	Date	Approx. Time spent	Supervisor(s) present
10	26/04/18	1 hour	Danielle De Boos and Anna Tickle

Trainee's comments

SUMMARY OF PROGRESS since last recorded meeting (edit/expand subsections as necessary):

Review of agreed actions from last meeting:

Themes were drafted and had been returned by Danielle via email for feedback. A process diagram had been created outlining themes and subthemes.

Achievements:

Building a conceptual understanding of the data.

Difficulties/challenges:

Ensuring representation of participants

Adherence to time-line:

Hopefully on schedule for submission end of May.

General progress:

A meeting was held for external input into the analysis with Anna due to Sharron currently being off work. The thematic map was discussed and amended based on discussion. Some of the themes and subthemes were refined. Discussion was also held about how to report the data – all of the themes and subthemes will go into the main paper, with extra quotes in the extended to support the journal paper and ensure all participants are represented. It was also felt beneficial to include two different examples of an individual participant going through the process in the extended paper.

Supervisor's Report (Brief details of any problems and how they have been resolved. Detailed information is required only if student progress is unsatisfactory):

PLAN OF ACTION until next recorded supervisory meeting (to be briefly itemised by trainee, discussed with and approved by, supervisor)

PLAN:

- To refine thematic map
- Re-write results based on the discussion of the meeting

Student's concerns/problems/comments:

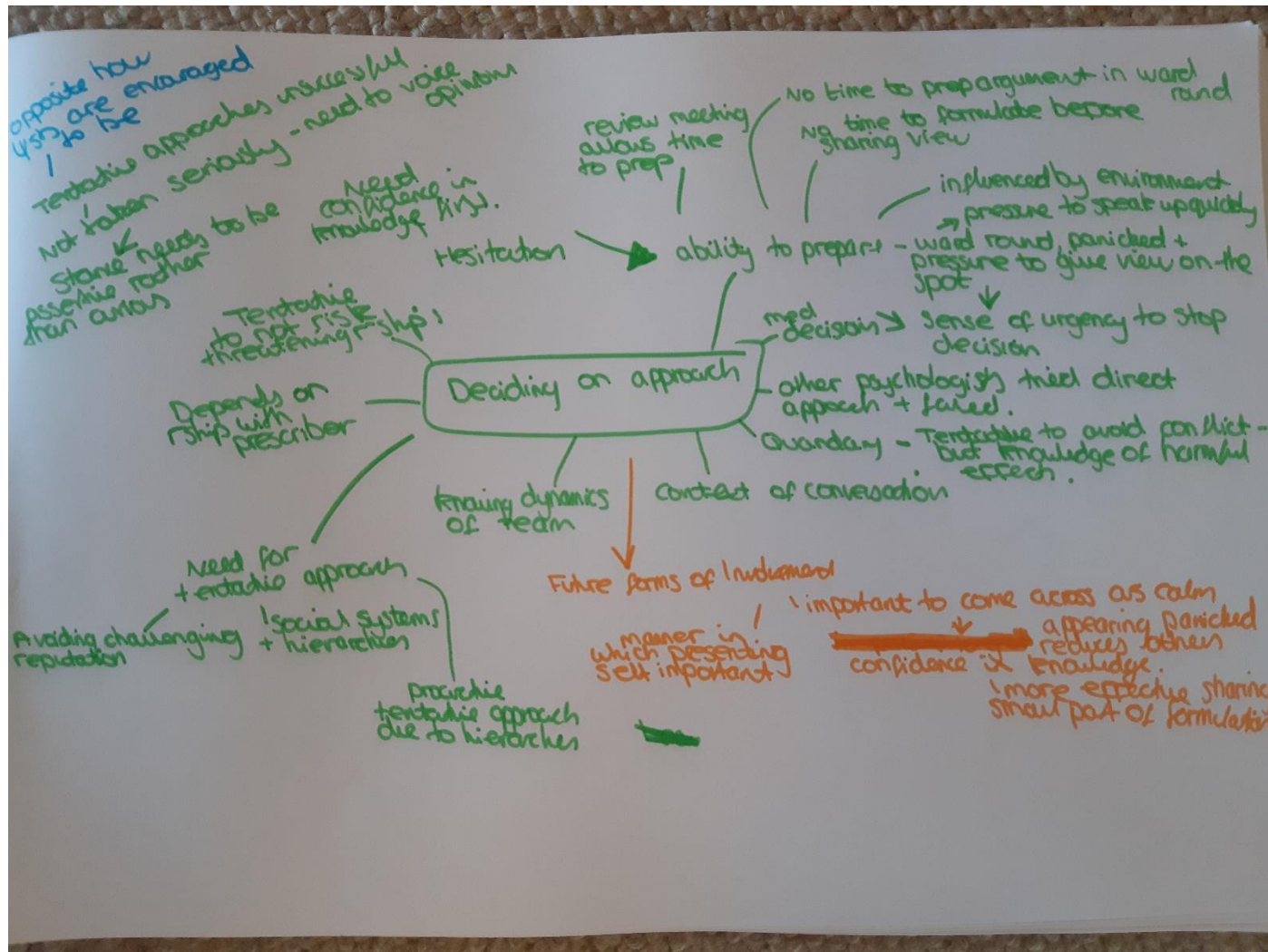
Signed: (Supervisor) **Date:**

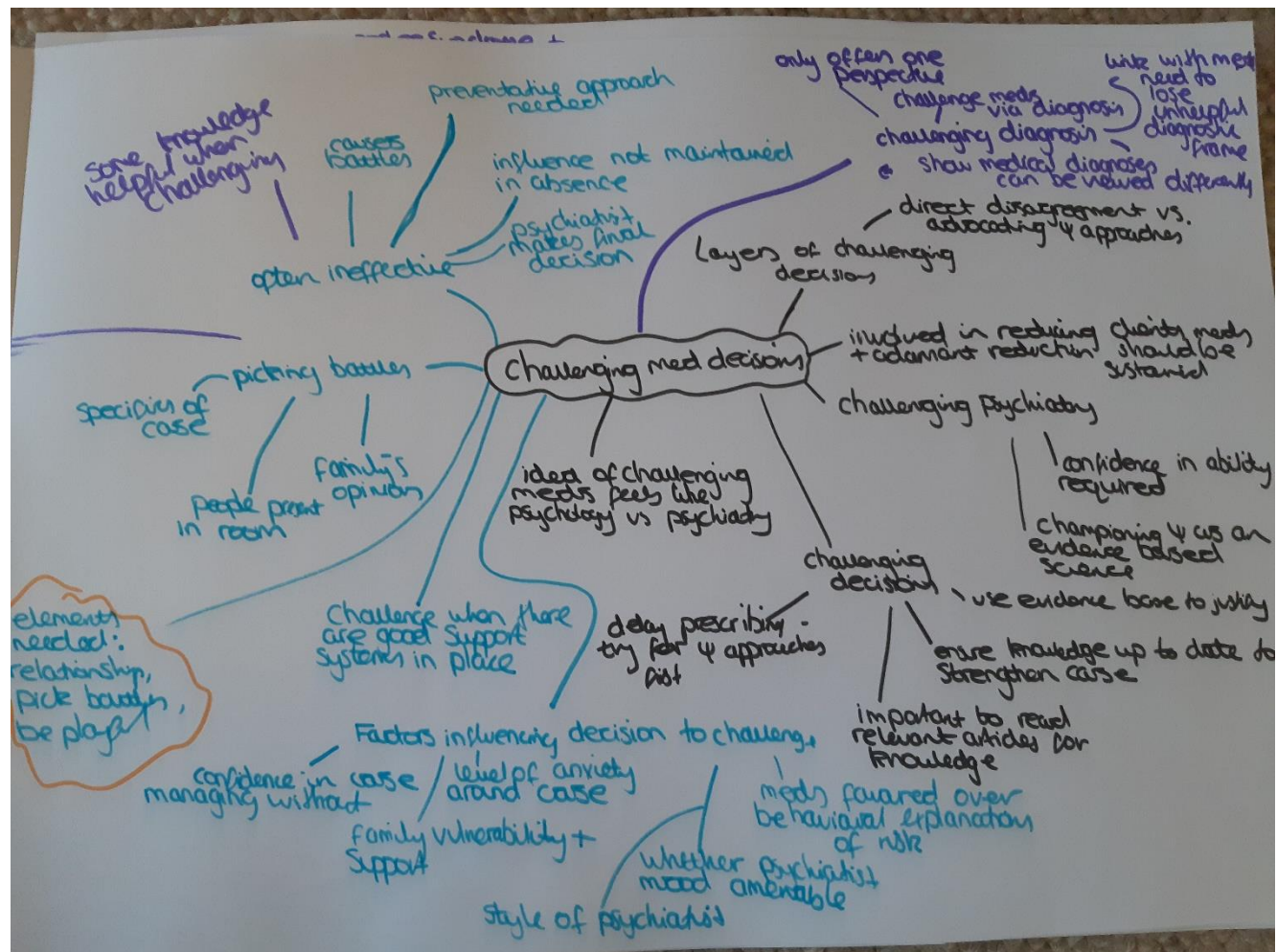
Signed: (Student) **Date:**

Appendix T: Prominent Concepts across Transcripts

	A	B	C	D	E	
1	1	2	3	4	5	
2	Personal opinions	Personal opinions	Personal attitudes towards medication	Personal views	Views/feeling towards medication	Personal st
3	Effectiveness of meds	Effectiveness of meds		Effects of medication		Effects of i
4	View on role	View on role			View on role	View of ro
5	Opinion medication or diagnosis specific					
6	Circumstances to query or challenge	Circumstances to query or challenge				
7	Reasons to increase knowledge	Reasons to increase knowledge	Increasing knowledge			Increasing
8	Ways of increasing knowledge					
9	Professional boundaries	Professional boundaries	Role boundaries	Role remit/boundaries	Remit/boundaries	
10	Hesitation	Hesitation				
11	Tipping scales to challenge/query	Tipping scales to challenge/query				
12	Putting into action	Putting into action	Actively challenging anti-psychiatry/anti-meds critique			
13	Clients perception of discussing meds with psychologist	Clients perception of discussing meds with psychologist				
14	Unsuccessful action			Negative experiences of involvement		Unsuccess
15	Medication use through psychology lens	Medication use through psychology lens				
16	Wider societal factors	Wider societal factors				
17	Service context	Service context				
18	Training		Training	Training	Training	
19	Other	Other	Other			Other
20		Reasons for wider forms of involvement				
21		Professional identity	Role identity	Professional identity	Professional identity	Profession
22		Working with colleagues		Colleague relationships	Working with colleagues	Working w
23		Service culture	Culture			Culture
24			Empathising with client position			
25			Reasons not to be involved			
26			Increased likelihood of involvement			
27			Forms of involvement	Forms of involvement	Forms of involvement	Forms of i
28			Barriers to promoting alternatives to medication			
29			Clinical training		Clinical training	

Appendix U: Mind-map Examples



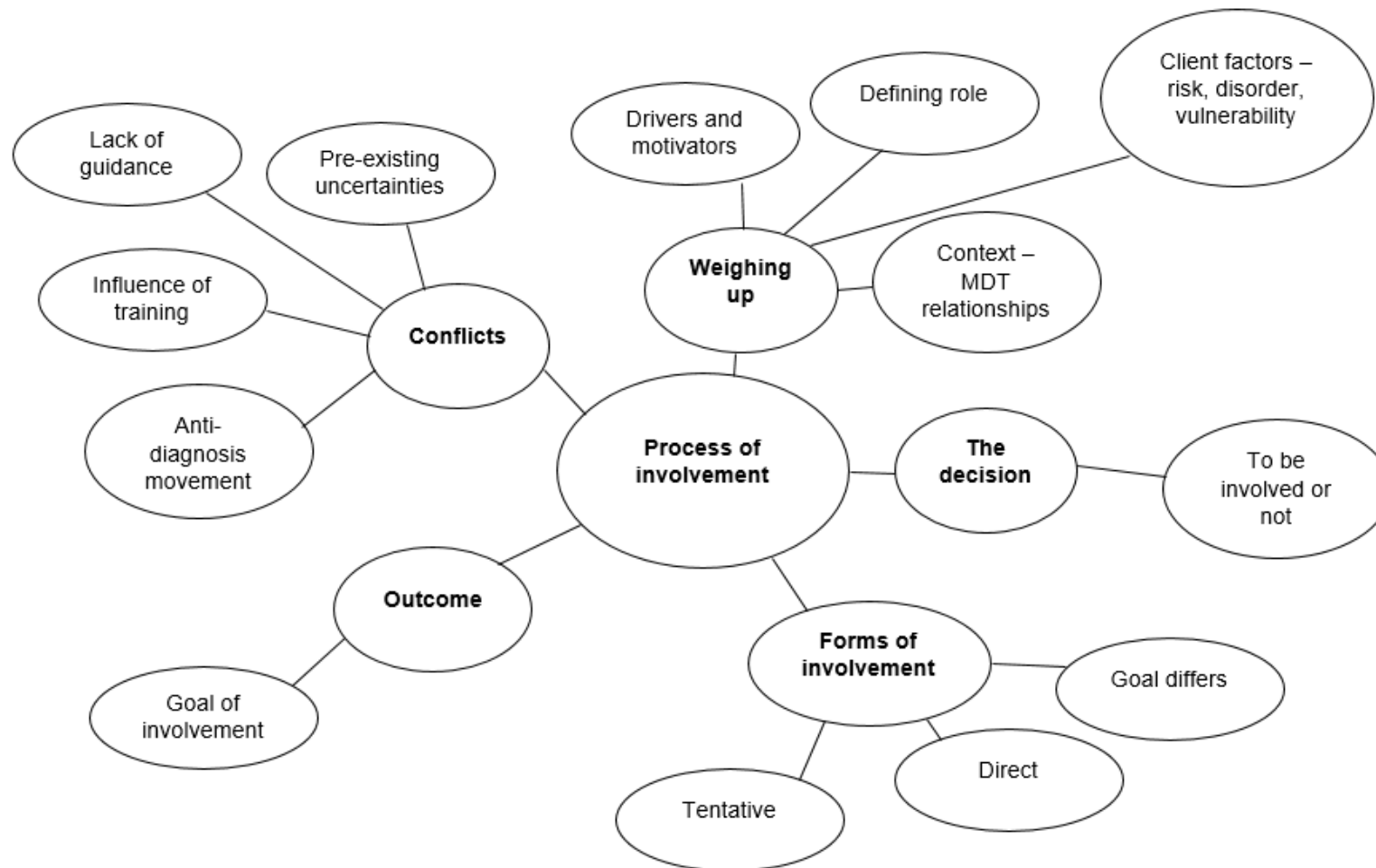


Appendix V: Deductive Coding Example

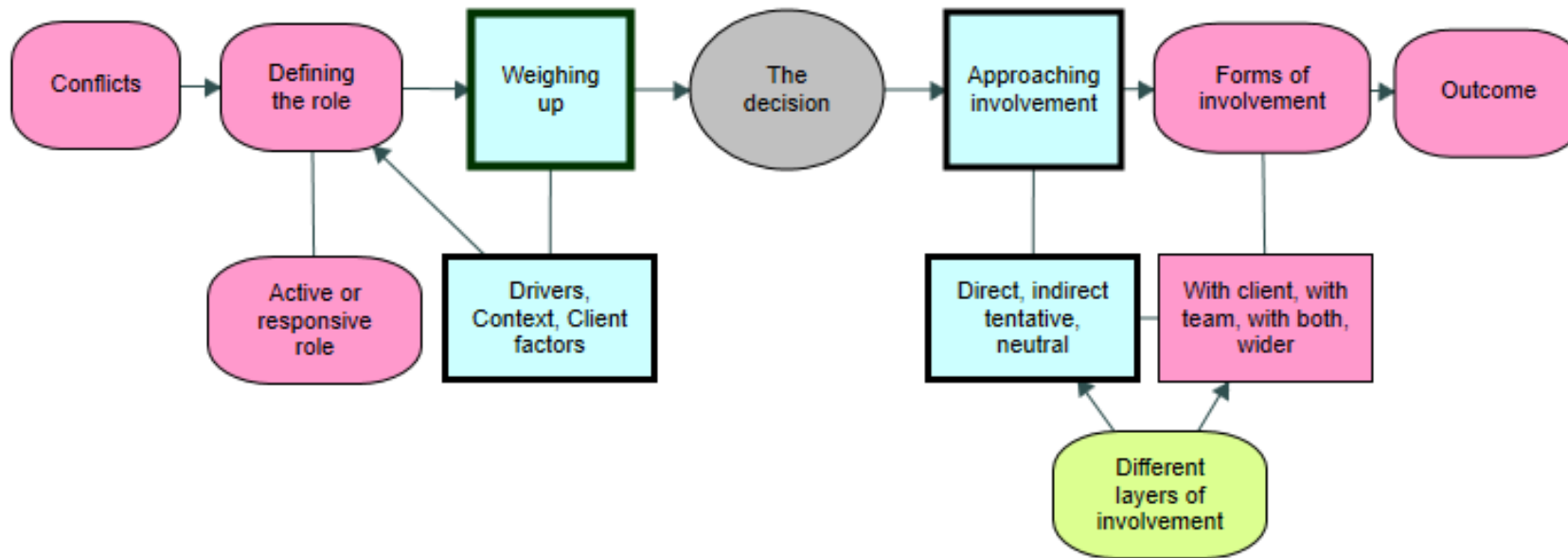
Nodes

Name	Sources	References
3 most important - be involved in decision making process to prescribe a SU meds	1	1
3 most important - be involved in decision making process to prescribe a SU meds [contradiction - doesn't happen]	1	1
3 most important - engage in a collaborative discussion with SU to help decision making	3	4
3 most important - reflect with SU on general experience of taking meds	1	3
3 most important - support SU to discuss meds with prescriber	2	4
CAMHS - more likely to be involved in decision making process to prescribe meds	2	2
Collaboration in decision making about meds important - client facing a power imbalance	2	2
Collaboration in decision making about meds important - clients opinion isn't heard	1	3
Concerns - concern about side effects	7	12
Concerns - concern about side effects [contradiction - seen positive use & little side effects]	1	1
concerns - inappropriate use	3	4
Concerns - long term use	5	8
Concerns - risks of medication underplayed	6	8
concerns - used as first line treatment	7	7
Dominant mental health paradigm - meds perpetuates biological understandings	6	13
Dominant mental health paradigm - widely held beliefs pills fix problems	7	11
Effectiveness of meds as an intervention - client and their difficulties not being understood	6	8
Effectiveness of meds as an intervention - difficulties unresolved	5	5
Effectiveness of meds as an intervention - False sense of hope	3	5
Effectiveness of meds as an intervention - not addressing underlying needs	5	9
Effectiveness of meds as an intervention - not person centred	1	1

Appendix W Mind-map of Salient Themes



Appendix X: Initial Thematic Process Diagram



Appendix Y: Test for collinearity

		Coefficients ^a						
		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
Model		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	.016	.033		.477	.634		
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Adult Mental Health	-.005	.031	-.017	-.152	.879	.585	1.709
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Child and Adolescent	.017	.037	.048	.460	.646	.652	1.535
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Intellectual Disability	-.019	.043	-.044	-.448	.655	.743	1.346
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Older Adult	-.020	.045	-.043	-.446	.656	.751	1.332
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Physical Health	.026	.036	.067	.731	.466	.838	1.193
	Which type of service do you work in? (Please select more than one if applicable) - Selected Choice Other	.016	.035	.048	.472	.637	.684	1.461

a. Dependent Variable: What kinds of involvement have you had with psychotropic medication in the last six months? (Please tick all that apply) - Selected Choice None

Appendix Z: Tests for Power

Option of involvement	Frequency option selected	Frequency option not selected
None	144	3
Referral to a psychiatrist/other prescriber for psychotropic medication	74	73
Consulted with a psychiatrist/other prescriber about changing a service user's psychotropic medication	56	91
Involved in the decision making process to prescribe a service user psychotropic medication	82	65
Discussed psychotropic medication issues within individual service user sessions	30	117
Discussed psychotropic medication issues in group therapy sessions	132	15
Supplied information about psychotropic medication to a service user	98	49
Requested or recommended that specific psychotropic medication be prescribed for a service user	117	30
Requested or recommended that a service user be taken off a specific psychotropic medication	118	29
Engaged in a collaborative discussion with a service user to support them in making a decision about their psychotropic medication	46	101
A psychological or neuropsychological assessment prompted recommendations for psychotropic medication	119	28

Option of involvement	Frequency option selected	Frequency option not selected
Using psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects	134	13
Reflecting with a service user on how their psychotropic medication may affect their engagement with psychology	74	73
Reflecting with a service user on their general experience of taking psychotropic medication	27	120
Taking the time to research information about a service users' psychotropic medication (e.g. internet search, asking colleagues)	65	82
Supporting service users to discuss their psychotropic medication with their prescriber	41	106
Sufficient power = minimum 60		

Appendix AA: Significant Results

Involved in the decision making process to prescribe a service user psychotropic medication (last 6 months)

		Variables in the Equation					
		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1 ^a	AdultMentalHealth	.209	.475	.194	1	.659	1.233
	CAMHS	1.351	.572	5.587	1	.018	3.863
	ID	2.066	.729	8.022	1	.005	7.891
	OlderAdult	-.410	.751	.298	1	.585	.664
	PhysicalHealth	.467	.535	.761	1	.383	1.595
	Other	1.196	.529	5.110	1	.024	3.308
	Constant	-1.130	.518	4.766	1	.029	.323

a. Variable(s) entered on step 1: AdultMentalHealth, CAMHS, ID, OlderAdult, PhysicalHealth, Other.

Requested or recommended that a service user be taken off psychotropic medication (last 6 months)

		Variables in the Equation					
		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1 ^a	AdultMentalHealth	.675	.605	1.244	1	.265	1.964
	CAMHS	-.967	.886	1.190	1	.275	.380
	ID	2.890	.754	14.702	1	.000	17.997
	OlderAdult	.170	.890	.036	1	.849	1.185
	PhysicalHealth	.277	.740	.140	1	.708	1.319
	Other	.508	.628	.655	1	.418	1.662
	Constant	-2.278	.651	12.236	1	.000	.102

a. Variable(s) entered on step 1: AdultMentalHealth, CAMHS, ID, OlderAdult, PhysicalHealth, Other.

Using psychological and/or neuropsychological tests to monitor and measure psychotropic medication effects (last 6 months)

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1 ^a	AdultMentalHealth	.890	.664	1.799	1	.180	2.435
	CAMHS	1.391	1.080	1.660	1	.198	4.021
	ID	.373	1.223	.093	1	.760	1.452
	OlderAdult	1.109	1.319	.708	1	.400	3.032
	PhysicalHealth	1.379	.836	2.723	1	.099	3.970
	Other	3.005	.884	11.565	1	.001	20.179
	Constant	-4.550	.931	23.873	1	.000	.011

a. Variable(s) entered on step 1: AdultMentalHealth, CAMHS, ID, OlderAdult, PhysicalHealth, Other

Do Clinical Psychologists Have a Role in Clients' Use of Psychotropic Medication?



Amy Aston, Sharron Smith, Danielle De Boos & Anna Tickle
Trent Doctorate in Clinical Psychology



BACKGROUND

Psychotropic medication refers to drugs capable of affecting the mind, emotions, and behaviour which are commonly prescribed for the treatment of 'mental illness'¹. Involvement with psychotropic medication is not traditionally viewed as an aspect of the clinical psychologists job, and there are currently no professional guidelines advising on a role.

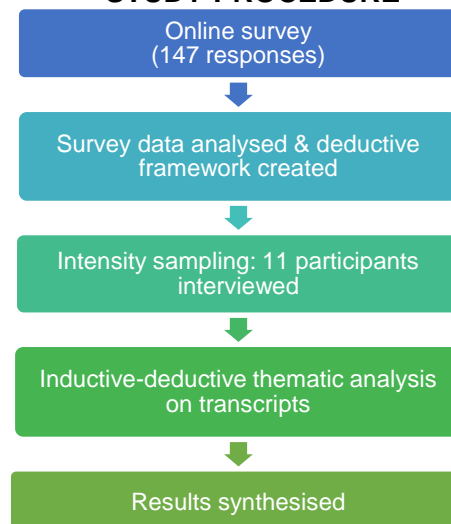
International research suggests that psychologists are likely to encounter a variety of opportunities to become involved, and are frequently (indirectly) involved in the process of prescribing and managing of clients' psychotropic medications². There is a lack of research into psychologists' involvement with psychotropic medication in the United Kingdom (UK), but given the widespread use of psychotropic medication similar opportunities and practice may occur³.

The collective clinical psychology profession is also taking an increased stance against biological approaches towards mental health such as issuing guidance on use of diagnosis and promoting movement away from its use⁴. The question remains as to whether the professional movement with diagnosis extends into any role with psychotropic medication, be this a critical stance or any other.

OBJECTIVES

1. What accounts do clinical psychologists provide in terms of their involvement in clients' experience or use of psychotropic medication?
2. What rationales or reasons do clinical psychologists provide for the choices they make in this involvement?

STUDY PROCEDURE



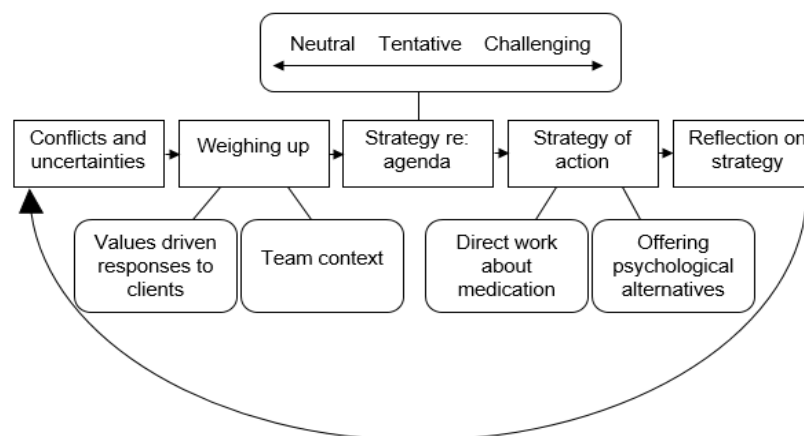
RESULTS

Online Survey Findings

- 98% of participants reported they had recent involvement with clients' of psychotropic medication.
- The most frequent forms of involvement were:
 1. Reflecting with a client on their general experience of taking psychotropic medication
 2. Discussing psychotropic medication issues within individual client sessions
 3. Supporting clients to discuss their psychotropic medication with their prescriber
- Participants working in child and adolescent mental health services (CAMHS) and intellectual disability (ID) services were more likely to have been involved in the decision-making process to prescribe a service user psychotropic medication.
- Participants working in ID services were also statistically more likely to have requested or recommended that a service user be taken off psychotropic medication

Interview Findings

The thematic map (below) demonstrates a prominent narrative within the data of the process by which a clinical psychologist weighs up factors prior to deciding to have involvement, and then flexibly navigates their approach and actions.



Synthesis

- The survey data was largely supported within the interview data.
- Many forms of involvement within the survey were discussed during interview, but qualitative exploration enabled increased forms of involvement to arise e.g. directly challenging prescribing, using formulation to challenge diagnosis and prescribing.
- Participants working in CAMHS and ID services reflected a need to advocate on behalf of clients, possibly explaining increased involvement with decision-making and making recommendations about medication.

METHOD

A mixed method sequential explanatory design was used to meet the study objectives.

Online survey

An online survey was used asking participants to select options of involvement they had engaged with in the last six months, and their general views on psychotropic medication.

Interviews

Intensity sampling was used to select participants who engaged in high and low levels of involvement and worked in a variety of services. Eleven participants took part in semi-structured interviews.

Analysis

Survey data were analysed using descriptive statistics and logistic regression analyses. Qualitative data from the survey was coded and organised into themes. Both data sets were combined to form a deductive framework. Interview data were analysed using a dual inductive-deductive thematic analysis.

DISCUSSION

- Clinical psychologists are regularly engaging in roles with their client's psychotropic medication. This is despite lack of guidance from professional bodies, no professional position statement, and minimal (or no) teaching during training.
- Involvement was both driven and justified by the belief that it was integral for remaining loyal to personal and professional values, frequently noting it was in clients' 'best interests'.

Implications

- Teaching on psychotropic medication during training would be helpful given the extent to which clinical psychologists are involved.
- Guidelines for clinical psychologists would help provide backing and consistency.

Limitations

- Potential for self-selection bias although attempts were made to control for this.

Future research

- Future research may work towards creating guidelines for clinical psychologists on working with psychotropic medication in practice. This might be done using consensus methods, such as a Delphi approach.

References

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